State Title V Block Grant Narrative
State: CA
Application Year: 2004

Viewing the Narrative: This view version displays the narrative. The narrative in the view version is displayed in the order of section and subsection from the Guidance's Table of Contents for Part II. Where a section of the narrative does not require text from the State, standard language is provided. If you wish to edit any of the narrative that you see, you must go back to the text entry page for that section to edit your narrative copy.

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1. From the tool bar, Select "File," the "Print Preview." The view version of the narrative will be displayed in print preview mode.
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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

View Attachment

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

View Attachment

C. Assurances and Certifications

See Attachment for the State of California’s Assurances and Certifications and Memorendum's of Understanding.

Attachment - Available Upon Request

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

View Attachment

E. Public Input

/2004/ An abridged draft of the FY2003-04 Application/Report which included key updates to the full report, including data tables, was posted on the Maternal and Child Health (MCH) Branch website for review and comment. MCH partners, including local MCAH Directors, contractors and other stakeholders were advised of the availability of the draft. The Children's Medical Services (CMS)Branch made the draft Application/Report available to its stakeholders, including the California Children's Services (CCS) administrators, local Child Health and Disability Prevention (CHDP) program directors, deputy directors and medical consultants, and CMS Branch staff.//2004//

See Attachment for further details on Public Input. Grant Recommendations are also included in this attachment.

View Attachment

II. Needs Assessment

In application year 2004, the Needs Assessment may be provided as an attachment to this section.

View Attachment

III. State Overview

A. Overview

Demography
California is the most populous state in the nation with a total population of 34,336,000 residents as of January 1, 2000(1). The state's population comprises 12 percent of the nation's total; one out of every eight of the nation's residents lives in California.

/2004/ California's population increased by 591,000 (1.7 percent) in the year 2002 to a total of 35,591,000 as of January 1, 2003. The population increase reflects a natural increase (births over deaths) of 289,590, and net immigration of 301,410.(1)//2004//

/2004/ California births decreased from 531,285 in 2000 to 527,371 births in 2001. The decrease is a result of a decline in fertility rate in the two youngest age groups (15-19, 20-24). The fertility rate for 15-19 year olds declined to a record low in 2001, about 39 percent lower than its 1991 peak. The youngest age groups are expected to continue to decline gradually before stabilizing after a few years. Birth rates have increased for older women (25-44), and are projected to rise throughout the projection period. Women over 29 had a record high fertility rate in 2001, with women aged 35-39 experiencing the greatest increase. The general fertility rate of 71.08 declined slightly compared to 2000. (2) Net immigration exceeded natural increase as a major source of population increase for the third year in 2002, although its share of growth declined from 53 to 51 percent. (3)//2004//

In 1998, California's population included 10,319,517 infants and children aged 0 through 19 years.
/2002/ In 1999, California's population included 553,480 infants less than one year of age, 7,656,985 children aged 1 through 14 years, and 2,324,018 adolescents aged 15

through 19 years of age.
/2003/ In 2000, California's estimated population included 2,782,020 infants and children under the age of five years, 4,582,188 children 5-12 years old, and 3,360,002 adolescents 13-19 years of age.

/2004/ In 2001, California's estimated population included 2,604,623 infants and children under the age of five years, 4,624,082 children 5-12 years old, and 3,706,318 adolescents 13-19 years of age for a total of over 10.9 million infants, children and adolescents. There were 7,734,745 women of childbearing age, 15-44 years old. (4) //2004//

California has a large and rapidly expanding adolescent population. From 1995 to 2005, the number of youth aged 10-19 residing in California will grow by 34 percent (4.4 million in 1995 to 6.0 million in 2005) compared to a 13 percent increase nationally. Over one and a half million more adolescents living in California will have an impact on the need for adolescent health services.

The number of Children with Special Health Care Needs (CSHCN) requiring services is increasing. Children with eligible medical conditions enrolled in California Children's Services (CCS,) the designated Title V CSHCN program, rose from 122,642 to 140,129 between 1997 and 1999.

/2004/ The number of children enrolled in CCS grew to 165,710 in FY 2001-02, more than five percent above FY 2000-01. The number of children receiving physical and occupational therapy services through the CCS Medical Therapy Program (MTP) rose more rapidly to 26,500, a 10.4 percent increase in FY 2001-02. (5)//2004//

Racial and Ethnic Diversity
/2004/ California is the nation's most ethnically diverse state, with Hispanics constituting the fastest-growing ethnic/racial group. The State's population is comprised of 34.5 percent Hispanics, 12.2 percent Asians and Pacific Islanders, 6.1 percent African Americans, 45.7 percent Whites. One percent of individuals are other races and ethnicities. The Hispanic median age (25 for males and females) is 6 years younger than the median age for the remaining overall population (31 for males, 33 for females), and 12 years younger than the median age of the White non-Hispanic population (37 for males, 39 for females). (6) //2004//

Please see the Attachments for the distribution of California's Population by Race and Ethnicity.

Thirty-three percent of California residents speak a language other than English in the home, compared with 14 percent nationwide. More than one-third of school-age children speak a language other than English at home. Spanish is the most widely spoken language after English. Languages of the Southeast Asian and Pacific Islander populations also contribute to the state's linguistic diversity.

/2004/ California has 28.1 percent of the nation's foreign-born population as its residents. (7)//2004//

The state's cultural diversity places added demands on the health care system in relation to both access to and quality of care. To improve access to Medi-Cal services, all Medi-Cal managed care (MCMC) materials are to be made available in ten threshold languages.

/2004/ California's cultural and linguistic diversity represents a barrier to health care for

those with Limited-English Proficiency (LEP)—20 percent of all Californians. In 2003, almost 50 percent of California's Medi-Cal and Healthy Families (HF) recipients primarily speak a language other than English.(8) //2004//

Please see the Attachments for a comparison of California's Ethnic Population from 1999-2000.

Geography
California's 34 million residents are distributed over 58 counties. The state's population is predominantly urban with over 92 percent of the state's residents living in urban areas.

/2004/ California's 35.6 million people reside in 58 counties ranging in size from Alpine, with a population of 1,210, to Los Angeles, with 9.98 million. The three largest—Los Angeles, Orange and San Diego—experienced growth rates of 1.7, 1.6, and 1.8 percent, respectively, in 2002.//2004//

The state's geography also contributes to access to care problems. The 2.5 million rural residents, while comprising a small portion of the state's population, often require unique responses to their health care needs. Rural residents are generally older, poorer, and have fewer health resources than their urban counterparts.

/2002/ Rural populations have higher rates of uninsurance (20% vs. 16%) and are typically uninsured for longer periods of time when compared with urban populations. (9)

/2004/ Barriers to access to health care for rural areas remain significant as the availability of providers remains a major problem in the more remote areas. The State is challenged to address the access issue through innovative ways now available through technology such as telemedicine.//2004//

/2004/ CCS is actively pursuing the improvement of access for children in rural areas of the state through a variety of methods. CCS has partnered with the University of California Davis (UCD) and Sutter Memorial Hospital to increase the use of telemedicine in delivering pediatric specialty level services to remote areas of Northern California for children enrolled in the CCS program. Currently UCD pediatric cardiologists use tele-echocardiography on a 24/7 basis with the CCS approved Mercy Medical Center Neonatal Intensive Care Unit (NICU) in Redding. Tele-echocardiography has assisted the facility to meet CCS program standards for NICU quality care of neonates, and more precisely defines the need for infant transports to Regional NICUs. Additional services being evaluated as appropriate for a telemedicine approach are endocrine disorders; e.g., diabetes control, and other cardiac conditions.

/2004/County CCS programs located in rural areas have increased reimbursement through Title XIX funds of maintenance and transportation expenses for children and their families needing help in accessing medical care at CCS approved Special Care Centers (SCCs), which are located in metropolitan medical centers; e.g., Children's Hospitals and University of California Medical Centers. //2004//

Economy
/2004/ California's economy continued to suffer in 2003 with the unemployment rate rising to 6.6 percent at the end of March 2003 (10, 11). The economic downturn has resulted in a state budget deficit approaching $37 billion, posing a significant threat to the health care delivery system and the public health infrastructure. The State budget has not been passed for the State's FY 2003-04; expenditure reductions continue to be proposed and debated.//2004//

As the economy suffers, California's low-income families (less than 200 percent FPL) experience even greater insecurity about the ability to meet the basic needs of their children. In times of prosperity, additional resources are more likely to be made available to address the health needs of the under-served if those needs remain in the public forum, a role that the Title V agency plays in identifying, responding to, and creating an awareness of those needs.

/2004/ In March 2002, 18.4 percent of California's children under five years, and 16.7 percent of children 5-17 years, were living in poverty. (12) Among families with children, 7.4 percent were living in poverty. Of those 598,000 families, 46 percent were single-parent families with a female head.(13) An estimated 30.5 percent of children under five years and 24.1 percent of children 5-17 years were enrolled in Medi-Cal, California's Medicaid program. The cost of health care for low-income families is rapidly increasing in the poor economy and the number of children eligible for Medi-Cal increases.(14)//2004//

Summary of the State's Health Care Status
/2004/ California has a very rapidly growing, ethnically diverse population residing in a geographically large state with extremes of population density and distance resulting in significant challenges in providing appropriate access to preventive, primary, and tertiary health care. At the same time it is facing its most difficult economic situation in decades, severely limiting the fiscal resources needed to address the health care needs of its population. The economic situation has aggravated an already difficult time for providers which further weakens the health care resources available to meet the needs. However, given these barriers and challenges, California continues to move ahead in assuring continuing access to basic health care needs by increasing the percentage of children with health coverage, creatively addressing the rising incidence of preventable disease, dealing with the problem of potential bioterrorism, and embracing technology to improve the accessibility of services and health care knowledge. //2004//

/2004/DHS 2002 Strategic Plan identifies six key issues as the highest priorities to be addressed. The issues are: optimizing public health capacity, improving coverage and access, improving health status and outcomes, fostering integrated service delivery, developing employee capability, and improving business processes. The Title V programs address these priorities and others identified by their partners and constituencies through activities and major initiatives.//2004//

Private Sector Participation in Health Services
The private sector is the principal provider of California's health services, including services for low-income populations. Programs such as the Child Health and Disability Prevention (CHDP), Comprehensive Perinatal Services (CPSP), and Family Planning Access Care and Treatment (Family P.A.C.T.) offer services through a broad network of providers in private practice, community health centers, and other private non-profit clinics.

/2004/ The CHDP program provides health assessments for children from families having incomes less than 200 percent of FPL. In FY 2000-01, the CHDP program provided health assessments to 2,193,157 infants, children, and adolescents, a decrease of 1.6 percent from FY 1999-00. MCMC plans screened 735,044 (33.5 percent) of that total, a 5.6 percent increase from the prior year. (15) The number of CHDP services delivered by MCMC plans continues to increase, however, an unknown percentage of plan assessments likely remain unreported due to incompletion of the "Information-Only" PM 160 reporting form which is not tied to compensation of the service.(16)//2004//

California's version of the State Children's Health Insurance Program, Healthy Families (HF), relies on the private sector delivery of health services to low-income working

populations. HF provides health insurance coverage to children from families with incomes up to 250 percent of the FPL who are above Medi-Cal eligibility limits.

/2004/As of March 2003, 639,909 children were enrolled in HF, more than a 50 percent increase over approximately two years(17).//2004//

A collaborative initiative between the California HealthCare Foundation and the State of California led to the development of Health-e-APP, a web-based Healthy Families Program application process. Pilot testing in six community-based organizations in San Diego County, resulted in improving the speed, accuracy, and consumer satisfaction with the application process.

/2003/ An evaluation of the Health-e-App pilot project in San Diego suggests that Health-e-App reduced the number of application errors by nearly 40 percent and reduced the time between application and final eligibility determination by 21 percent.

/2004/ Health-e-App is now available to all California Enrollment Entities (EEs). As of April 2003, over 25,000 Healthy Families and Medi-Cal applications have been submitted using the Health-e-App. Almost 1000 EEs have signed up to use the online application with over 300 EEs in 46 counties currently using it.//2004//

Health care services for CSHCN are an example of cooperation and coordination between private and State health care providers.

/2004/ The CCS program is moving aggressively through technology to decrease barriers to provider participation by increasing the efficiency of the program. A recently completed Web page (http://www.dhs.ca.gov/pcfh/cms) provides important information to providers on programs, program policies, forms and publications, and letters and notices. For years providers have been required to produce paper claims requiring a lengthy manual approval and adjudication process delaying payment significantly. A major contract for a developer has been awarded to develop the capacity for providers serving CCS children being case managed through the automated CMS Net system to submit claims electronically to the State's fiscal intermediary. This change will significantly reduce administrative cost for the providers, local agencies, and State; permit payment within a few days of submission; and provide for HIPAA compliance. Given the fragile nature of the CCS specialty care network, this will be a major step towards retention and recruitment of the providers needed to serve the CCS population. The State's SSDI grant provides partial funding for this effort.//2004//

Private foundations play a significant role in meeting the health needs of women, infants, children, and CSHCN by working in partnership with State and local government, and local communities.

Major State Initiatives
Early Childhood Development /Proposition 10: A State ballot initiative, Proposition 10, the Children and Families First Act, was implemented in 1998, imposing an additional surtax on cigarette sales. Proposition 10 will result in increased revenues of about $690 million in 1999-00, with slightly declining amounts annually thereafter. The price increase is also expected to contribute to reducing smoking among California's youth.
MCH and CMS work with other departments of the Health and Human Services Agency to identify best practices on home visiting, case management, family-centered care, and family resource centers which are pertinent to priorities of the California Children and Families initiative. Local MCH programs work directly with their County Children and Families Commissions in the planning of activities.

/2004/ The state-level commission, now called First Five California, receives 20 percent of the funds, while the local First Five Commissions in each of the 58 California counties receive the remaining 80 percent. The major "signature" initiative of First Five California is its School Readiness Initiative (SRI). First Five California has devoted $206.5 million over four years to SRI with local commissions being required to match the amount. SRI describes five "essential and coordinated elements," one element being: "health and social services, including services such as health plan enrollment; provision and/or referral to basic healthcare (e.g., prenatal care, services for children with disabilities and other special needs, oral health, and nutrition); comprehensive screening and assessment; mental health counseling; and others." Local MCAH directors work closely with their First Five Commissions in the preparation of local SRI proposals. First Five California has identified other "Focus Areas" which link with SRI. Some areas are linked to MCH program activities, specifically 1) The Migrant Families Initiative, 2) Children with Disabilities and Other Special Needs (to include early mental health), 3) Oral Health, and 4) Informal Care.//2004//

/2004/ First Five has three other efforts addressing "Early Health". They are 1) Childcare Health Linkages which link services of health agencies with childcare facilities; 2) The Infant, Preschool and Family Mental Health Initiative which funds eight counties to develop new mental health services for young children and their families; and 3) the Childhood Asthma Initiative (CAI) which funds eleven local projects and provider education. The State MCH Branch follows the activities of First Five and helps local staff identify the connections between their programs and First Five activities. //2004//

/2004/ In addition, the MCH Branch in collaboration with the University of California, San Francisco's California Child Care health program has applied for a MCHB-funded State Early Childhood Comprehensive Systems (SECCS) planning grant.//2004//

/2004/ The CMS Branch is part of the First Five Commission funded CAI that targets children with asthma between birth and five years of age. During the first 22 months of the CAI project, 312 children were enrolled in the Asthma Treatment Services (ATS) component of the project. Early outcome data indicates the quality of life for enrolled children and their families was improved. Notably, the percentage of children with persistent asthma with written asthma management plans increased from 35 percent to 80 percent.//2004//

Child Health Insurance Coverage: A second major State initiative is insuring children's access to health services through expanded health insurance coverage in order to improve the health of the Title V population. The key strategy for improving access to care is the expanded enrollment of Medi-Cal and Healthy Families Program (HFP) eligible children. The Title V Agency, through the School Health Connections (SHC) Section of the MCH Branch, has taken a lead role in conducting the state-based school outreach efforts for Healthy Families/Medi-Cal for Children (HF/MCC) as well as other affordable health coverage programs.

/2004/ Efforts to increase enrollment in the State sponsored children's health care coverage appear to be impacting the percentage of uninsured children. Estimates from the March 2002 Current Population Surveys indicate that the proportion of children 0-18 years who were uninsured (15.32 percent) declined slightly from 2000 to 2001 as a result of increases in employment-based insurance and enrollment in Medi-Cal and HF.//2004//

/2004/ CHDP Gateway: On July 1, 2003, DHS implemented an electronic "gateway" at CHDP provider offices and clinics to facilitate the enrollment of eligible children for up to two months of presumptive eligibility for Medi-Cal or HF health care coverage. Currently, approximately 1.1 million children who are not enrolled in HF or Medi-Cal receive CHDP

assessments. An estimated 760,000 of them are thought to be eligible for one of these programs. The CHDP Gateway contains the important features of electronic eligibility screening, enrollment of children receiving CHDP assessments into two months of no-cost full-scope Medi-Cal benefits, and an "extended enrollment" process into continuing Medi-Cal/HF coverage if a formal application is submitted within the two month initial period. Families can obtain medical or dental care immediately following the Gateway enrollment./2004//

/2004/ The CHDP provider screens all children for CHDP Gateway eligibility using an electronic pre-enrollment application either through the Internet or a Point-of-Service (POS) device. The pre-enrollment application contains the same eligibility fields as the paper eligibility form (DHS 4073) and includes additional demographic information and other fields such as the social security number (optional). The paper eligibility screening form will be phased out by January 1, 2004. The Gateway process checks the Medi-Cal Eligibility Data System (MEDS) to determine if the child is currently a Medi-Cal or HF beneficiary. If not a beneficiary, it checks if the child is "known" to MEDS as ineligible for Medi-Cal and HF but has already been screened through the Gateway and determined to be only eligible for state-funded CHDP periodicity visits. If no record exists for the child, a new MEDS record is created using the eligibility screening information and an assigned Client Identification Number. For each new child accessing the Gateway system, parents/guardians are asked if they wish to apply for continuing Medi-Cal or HF coverage and if the response is affirmative, a joint Medi-Cal/HF application is automatically sent to their home address. If the family completes the application and returns it, the Medi-Cal benefits are extended until the child is determined eligible or ineligible for either Medi-Cal or HF.//2004//

Oral Health Promotion
The Department of Health Services is responding to the high prevalence of dental disease among California's children with a variety of strategies to increase awareness of oral health as an integral component of comprehensive primary care, and to promote effective prevention strategies.

MCH Branch staff are working to insure the inclusion of oral health promotion activities within existing programs of the Branch and the Division of Primary Care and Family Health. Prominent among these efforts has been the development of a revised edition of the Comprehensive Perinatal Services Program (CPSP) guidelines that will include oral health guidelines for pregnant women, infants, and children. These will be used by local MCH program staff during consultation to women during and after pregnancy.

/2004/ The MCH Branch continues to use the CPSP guidelines to promote oral health in pregnant women, infants, and children. Toothbrushes and children's fluoride toothpaste have been distributed to local MCH programs including Adolescent Family Life Program (AFLP), Black Infant Health (BIH), and CPSP as incentives and education tools. //2004//

In order to meet the growing demand for technical assistance at both the state and local levels, the MCH Branch has contracted with UCSF for a licensed dentist to serve as the MCH Oral Health Policy Consultant.

/2004/ In the fall of 2002, the MCH Oral Health Policy Consultant, MCH Nutritionists, Pediatric Consultant and members of the DHS Dental Workgroup developed oral heath educational materials. The MCH Branch oral health program in collaboration with the Dental Health Foundation is addressing the oral health needs of young children in California through a grant from the MCH Bureau. The first consensus conference was held in the fall of 2003 in Sacramento.//2004//

/2004/ In February 2003, the State Committee for the Protection of Human Subjects approved the study entitled "Xylitol chewing gum as an adjunct to caries prevention measures: a pilot study on compliance in California public health programs". The main goals of the study are to evaluate the implementation of a xylitol caries prevention program in conjunction with a traditional dental health education program in a high-risk population, and to determine the compliance with the use of daily xylitol chewing gum for caries prevention. The study will begin in the fall of 2003 in Kern and San Bernardino counties. The target population is approximately 200 adolescent and adult mothers in the BIH and AFLP.//2004//

Several counties have allocated funds from their local First Five Commissions for services related to oral health. In addition, the State First Five Commission has listed oral health as one of its five priorities. All of these initiatives are indicative of the State's commitment to combating dental illness in the MCH population through prevention and improved access to care.

/2004/ A Request For Application for $7 million dollars for oral health activities will be soon released by the First Five Commission. . One million of the $7 million is committed to public education. The remaining is to be used to train and educate dental and non-dental health care providers on the importance of oral health in early childhood. An additional $3 million will fund MRMIB. The MCH Branch staff has been actively involved in the planning and working with potential grantees to assure MCH related programs and staff will be included in this $10 million initiative.//2004//

The CMS Branch continues to work toward improving oral and dental health in California's children, through the CHDP and CCS programs. Assessments of oral health are part of each CHDP health assessment examination. Certain dental abnormalities were included as conditions that allow CCS program eligibility, in the final CCS regulations (issued July 2000), and dental problems that impact on a CCS medically eligible condition are being covered as part of CCS case management.

/2004/ Current CMS Branch oral health activities include developing an "Orthodontic/Dental Handbook" to assist orthodontists and dentists to understand the CCS program and accept more CCS children into their practices. The handbook is being developed with input of the California Association of Orthodontists. A shortage of orthodontists willing to serve CCS children is requiring the Branch to evaluate its policies and processes for these providers. In FFY 2000-01, 1,807,139 children received dental screenings through the CHDP program with 68 percent Hispanic, 9 percent White, 6.5 percent Black, 4.8 percent Asian, and the remainder other ethnic groups or unknown (18).The CHDP Gateway with its two months of pre-enrollment of children into Medi-Cal or HF is a temporary source of reimbursement for dental treatment for CHDP children. A major challenge is identifying adequate numbers of dentists to meet the increasing need. In April 2002, Denti-Cal added 10 dental procedures as covered benefits for selected pregnant women enrolled in Medi-Cal. These procedures were added based on recently published data regarding a possible association between preterm and low-birth weight babies and periodontal infection.//2004//

/2004/ Kern County's CHDP program has used local Proposition 10 funding to provide oral health promotion and treatment services through promoting the idea of a "dental home" and working with community groups to avoid duplicating dental services and to share plans that work.//2004//

Preventing Childhood Obesity
California, like the nation, is experiencing an increase in the prevalence of childhood obesity and related health problems. Among low income children under age 12 years

who receive health care through CHDP, the percent overweight has risen from 12.4 percent in 1990 to 14.4 percent in 1999.

/2004/ Pediatric Nutrition Surveillance System (PEDNSS) data show the percentage of low-income children under 5 years receiving healthcare through CHDP who are overweight rose from 12.1 percent in 2000 to 13.1 percent in 2001. For low income children 5 to 20 years, the percentage overweight has risen from 19.7 percent in 2000 to 20.0 percent in 2001. For children 2 to 5 years, the prevalence of risk for overweight rose from 15.0 percent in 2000 to 15.3 in 2001. For children 5 to 20 years, the prevalence for at risk for overweight rose from 17.7 percent in 2000 to 17.9 percent in 2001. Ethnic variation in the prevalence of overweight still exists, with the highest prevalence in American Indian/Alaskan Native for children 5 years to less than 20 years at 25.6 percent for 2001. The second highest ethnic group in this age category is Hispanic children with a prevalence of 21.4 percent in 2001. For children less than 5 years, the prevalence of overweight was greatest for American Indian/Alaskan Native at 16.9 percent and next for Hispanic children at 16.3 percent(19).//2004//

In response to this growing problem, childhood obesity prevention has become a major statewide initiative. To expand the coverage and scope of programs implemented in response to the growing problem of childhood obesity, the MCH, CMS, and WIC Branches of the California DHS and the UC Berkeley Center for Weight and Health collaboratively hosted the first statewide California Childhood Obesity Prevention Conference in March 2001.

/2004/The second biannual statewide conference was entitled, "Making an Impact Now: Environmental, Family, and Clinical Approaches." This conference held in San Diego in January 2003 was the largest conference ever held on obesity prevention and received national attention.//2004//

/2004/ The Primary Care and Family Health Division awarded Healthy Eating and Childhood Overweight Prevention Grants to eight local public health agencies to implement community projects to combat childhood obesity among low-income school-aged children between August 1, 2002, and September 30, 2003. Grantees included a mix of rural and urban counties.//2004//

/2004/CHDP has implemented a pilot Nutrition Network Project at the elementary school level, to promote nutrition teaching, improve the nutrition value of foods available and increase physical activity during the school day. The pilot Nutrition Network Project will potentially fund eight CHDP nutritionist positions to provide nutrition education to low-income families and CHDP providers, an expansion from two previously funded in Merced and Sonoma Counties.//2004//

/2004/ SHC promotes healthy food choices and physical activity in schools through the endorsement of nutritional assessment tools, including the CDC's School Health Index. These tools assess physical activity and nutrition in the school environment and identify areas in need of improvement. CDAPP/Sweet Success has increased the emphasis on postpartum recommendations to prevent or delay the onset of maternal diabetes, childhood diabetes, and the early onset of Type II diabetes. Diabetes is now addressed as a family disease and pregnancy is used as an opportunity to educate patients about lifestyle risk factors and determine appropriate diabetes treatment. Emerging research on fetal programming in the intrauterine environment has recognized the cycle of diabetes from mother to child to mother. This adds impetus to the goals of providers in client education regarding the importance of a normal fetal glucose environment (fetal normoglycemia). AFLP, Adolescent Sibling Pregnancy Prevention Program (ASPPP), and the Oral Health programs have been provided guidelines and educational materials

to address healthy eating, including the five-a-day fruit and vegetable message. BIH and CPSP target the prevention of low-birth weight babies and promote breastfeeding, which have been documented to reduce the risk for developing obesity. BIH also has an anemia campaign supporting the food guide pyramid; promotes breastfeeding; and has been dialoguing on obesity and BIH's role in addressing the crisis.//2004//

The MCH and CMS Branches have been involved in the California Obesity Prevention Initiative (COPI). COPI, funded by CDC, includes an internal DHS coalition to assist in program planning, implementation and evaluation. In addition, the MCH Branch is involved in the Physical Activity and Nutrition Coordinating Committee (PANCC).

/2004/ Local MCH jurisdictions are increasingly addressing childhood obesity. Some new county-based childhood prevention activities in 2003 include efforts in Marin, Stanislaus, and Trinity counties.//2004//

Eliminating Racial and Ethnic Disparities in Health
The elimination of racial and ethnic disparities in health status and health care access is essential to improving the overall health of California's population given the state's diversity. In line with this Title V priority, the California DHS supports a variety of programs to reduce disparities.

/2004/ MCH programs hire ethnically diverse staffs to recruit clients into care and employ a variety of unique methods to target diverse populations. The Orange County MCH program used matching funding through the First Five program to provide care coordination for pregnant women and their families. The local program called "Promotores," works with Hispanic pregnant women and their families to ensure they are enrolled in prenatal care and have access to all appropriate services. In Madera County, the MCH program was instrumental in developing the Healthy Beginnings Multi Disciplinary Team, which focuses on case management for high-risk families with children 0-5 years. The Madera County Extra Special Parents Group, Madera County Schools, Mental Health, and the MCH Program work collaboratively to provide services and case management to these high-risk families to ensure that they stay connected to medical providers and have access to appropriate health and social services.//2004//

The MCH Branch conducts ongoing assessments of disparities in relation to specific health outcomes and behavioral risks. A recent study by MCH Branch scientists showed a significant gap in our SIDS mortality rates and prevention activities among African-American infants in the state. A Back-to-Sleep program component for African American families was developed in response to this study. Additionally, the lower prevalence of folic acid and multivitamin use among Latina women of childbearing age (24) is being considered in the development of folic acid promotion materials.

/2003/The MCH Branch entered into a cooperative agreement with San Diego State University (SDSU) in 1994 to develop a computerized management information system for the Black Infant Health Program (BIH-MIS). An evaluation report of the BIH Program from 1994 through 1998 showed the program was effective in reducing the rates of very preterm delivery and very low birth weight among very high-risk women and their newborns (23).

/2004/ CPSP strives to increase cultural awareness in its programs by providing multilingual pamphlets and SIDS provides materials in Farsi, Hmong, Lao, Russian, Spanish, Vietnamese, and Tagalog.//2004//

State outreach efforts to increase health insurance coverage for low-income children have been designed to reduce the disproportionately high rates of uninsurance among

California's ethnically diverse populations, particularly Hispanic children.

/2004/ In 2003, almost 50 percent of California's Medi-Cal and HF members primarily speak a language other than English. To improve access to Medi-Cal services, all MCMC materials are to be made available in ten threshold languages. These include: Spanish, Chinese, Vietnamese, Cambodian, Hmong, Laotian, Korean, Russian, Farsi, and Tagalog. The CHDP and CCS programs are also developing information in threshold languages //2004//

The State is working to reduce health disparities through teen pregnancy prevention programs and expanded chlamydia detection and treatment. The analysis of racial and ethnic disparities is an integral component of the surveillance and evaluation activities of the MCH Branch.

The CHDP program serves children and adolescents from diverse groups, providing low income and uninsured populations with health assessments, screenings, and health counseling.

/2004/ In FY 2000-01, the ethnicity distribution of children and adolescents age 0 through 21 receiving CHDP program services was as follows: approximately 67.4 percent were Hispanic, 9.4 percent were White, 6.5 percent were Black, 4.5 percent were Asian, 0.3 percent were American Indian, 0.5 percent were Filipino, 0.2 percent were Pacific Islander, and 11.3 percent were identified as other or unknown. Except for the increase in the percentage of Hispanic children and youth, these percentages are similar to FY 1999-00, and indicate that a large segment of CHDP services are provided to Hispanic children and adolescents. CHDP brochures and other information resources are being translated into threshold languages to meet the needs of CHDP families and their children. (20)//2004//

Adolescent Health Promotion
The growth of California's adolescent population and growing awareness of adolescence as an opportunity for the prevention of health risk behaviors that are the leading causes of death among this age group, and major contributors to adult mortality, have led the State to expand its focus on adolescent health promotion. In response to the interest among County MCH Directors and local agencies, the MCH Branch is contracting with the National Adolescent Health Information Center (NAHIC) at UCSF to work with local programs to promote the plan and provide technical assistance in the development of activities. Local initiatives have been developed in response to the formulation and presentation of the plan.

/2004/ Alameda has put together the Alameda County Youth Health Services Coordination Team. The NAHIC has worked with the Adolescent Health Working Group to implement trainings on minor consent and confidentiality issues for teen patients in four counties: Fresno, Madera, Los Angeles, and Sonoma. NAHIC has also continued to share its strategic plan with local health care professionals as well as San Francisco State University.//2004//

/2004/ In September 2002, NAHIC in collaboration with the MCH Branch conducted a survey of the MCAH Directors to determine needs and priorities for the provision of technical assistance and training for the local MCAH Directors around adolescent health. The MCH Branch has been involved in the HRSA-sponsored Adolescent Health Core Capacities project to develop a framework for adolescent health for states and the core capacities needed to best address adolescent health on a statewide basis. The MCH Branch has also participated in the DHS Physical Activity and Nutrition Coordinating Committee and California Obesity Prevention Initiative's Health System. Federal funding

was utilized by the MCH Branch, in collaboration with the Nutrition Network and the Sutter Memorial Hospital AFLP, to publish a cookbook specifically designed for teens. The cookbook was widely distributed to MCH programs throughout the state, including AFLP, ASPPP, and BIH. The same funding source was also used to develop the Adolescent Nutrition Guidelines, which were distributed to AFLP/ASPPP providers statewide. In addition, the MCH Branch funds domestic violence (DV) shelters that have provided trainings to enable youth to foster healthy relationships, obtain feedback to identify gaps in services, work as peer counselors, and serve on the advisory boards.//2004//

/2004/Through a special project funded by the Nutrition network, older children and adolescents participating in the CHDP and AFLP programs have received color brochures of Food, Activity, and You from health care providers to educate them about healthy eating, physical activity, and weight management.//2004//

/2004/ The Adolescent Health Collaborative (AHC) met in December 2002 and focused on adolescent mental health issues related to prevention and early intervention. The State Adolescent Health Coordinator has been working with DHS, UCSF, and the Adolescent Health Working Group on a quality improvement project to improve adolescent health preventive services for teens. The State Adolescent Health Coordinator is also collaborating with the State Injury Prevention Director on areas around youth injury prevention.//2004//

Foster Care
Children and youth in foster care settings often do not receive necessary health care evaluations and services. They are high-risk individuals, who may have been neglected or abused, and often have unrecognized and untreated medical, mental and dental problems(26). California has over 100,000 foster children. To improve access to and oversight of health care for these children, the Health Care Program for Children in Foster Care (HCPCFC), which is a collaboration between the DSS and CMS, was created. This program is placing PHNs in welfare service agencies and probation departments, to assure delivery of preventive, diagnostic and treatment health services to children and youth in foster care.
/2003/ The Foster Care Program, implemented in January 2000, has established a process through which PHNs consult and collaborate with the foster care team members to promote access to comprehensive preventive health and specialty services. PHNs liaison with health care professionals and providers; assist in collecting and interpreting health care information; develop health care resources; and provide training for caseworkers, court officers, foster family caregivers, and others on the unique health care needs of children and youth in foster care.

/2004/ HCPCFC is administered locally by the CHDP program and works very closely with the local foster care programs. DSS audits of child welfare agencies and probation departments show 100 percent scores for case record documentation of CHDP comprehensive health assessments within 30 days of placement. Audit results for dental examinations during the same time frame show less than 100 percent due to the difficulty in accessing qualified dental providers. Statewide training sessions of PHNs, social workers, and probation officers on behalf of the child were completed in 2002 and 2003.//2004//

 View Attachment

B. Agency Capacity

The programs of the MCH and CMS Branches of DHS have been developed to address the three core public health functions: needs assessment of the population; development of program policies to address the needs and improve health outcomes; and assurance of the availability of accessible and appropriate high-quality services. Assuring cultural competence and access to services in a community-based setting are both important principles of DHS policy development.

Preventive and primary care services for pregnant women, mothers and infants

Support to Local Infrastructure:
MCH Branch staff and consultants support the local infrastructure's capacity for program planning and data analysis. The local jurisdictions work with Title V-supported programs and technical staff, such as the California Center for Childhood Injury Prevention and the National Adolescent Health Information Center at UCSF and the dental health consultant of the MCH Branch, to develop local responses to priority health needs. MCH Branch contracts with the UCSF Family Health Outcomes Project (FHOP) to provide consultation and training to MCH Directors and their staff at local health jurisdictions in monitoring and updating of their local five year plan, data collection, identification of data sources, data analysis and survey development.

/2004/ State statute established the Youth Pilot Program (YPP) and Integrated Health and Human Services Pilot which authorize a total of nine counties to implement programs which provide integrated, comprehensive services for children and their families. YPP focuses on high-risk, multi-need, low-income youth and their families and permits the blending of certain state funds. The YPP pilots allow counties to make decisions locally regarding the best use of state and local human services funds without the loss of state and federal funds. In addition, the State has the authority to waive State statute and/or regulations that are barriers to counties' strategic implementation plans. The pilots are directly under the auspices of the California Health and Human Services Agency. The six pilot counties under the YPP include Alameda, Contra Costa, Fresno, Marin, Placer, and San Diego. The three Integrated Health and Human Services Pilot counties are Alameda, Humboldt and Mendocino Counties. The YPP legislation is scheduled to sunset July 1, 2004 and the Integrated Health and Human Services Pilot legislation (AB 1259) is scheduled to sunset July 1, 2005.//2004//

Access to Maternity Services:
California has eliminated most financial barriers to reproductive and prenatal services for low-income women and preventive and primary services for infants. Medi-Cal eligibility for prenatal coverage includes all pregnant women with incomes below 200 percent of the Federal Poverty Level. A property disregard program expands eligibility.
/2003/In 2000, Medi-Cal covered the prenatal care and delivery costs of 39.5 percent of all women who delivered a live-born infant in California(25).

The Access for Infants and Mothers (AIM) Program provides State-subsidized third party insurance at low cost to pregnant women and infants between 200 and 300 percent of the FPL, if they are uninsured or otherwise meet eligibility requirements for AIM maternity benefits. The combination of Medi-Cal, AIM and private health insurance results in near universal health insurance coverage for prenatal and maternity care in California.

/2004/ In 2001, 14.5 percent of women delivering a live-born infant entered prenatal care after the first trimester, indicating that access to prenatal care in the first trimester is increasing. The MCH Branch is also targeting communities with greater healthcare needs; Title V grants support four American Indian clinics that provide case management and prenatal care. The American Indian Infant Health Initiative (AIIHI) provides for public

health nursing follow-up to high-risk American Indian families with children under five and to pregnant women. Projects are located in Humboldt, Riverside/ San Bernardino, Sacramento and San Diego.//2004//

/2002/The provision of enhanced support services through such programs as the CPSP, BIH, and AFLP can also improve prenatal care utilization and the overall quality of care. AFLP provides case management for pregnant and parenting teens to prevent or reduce second pregnancies, improve pregnancy outcomes, and strengthen parenting skills.

/2004/Currently 46 agencies provide AFLP services to approximately 11,406 teens in 43 California counties each year.//2004//

CDAPP promotes the reproductive health of women who have pre-existing diabetes or develop gestational diabetes in the preconception, prenatal, and postpartum periods by applying standardized assessment and treatment protocols.

/2004/The CDAPP program has nearly 200 affiliate sites throughout the state. CDAPP affiliates have completed a provider training program and have agreed to adhere to program protocols for pregnant diabetic women. The program infrastructure has been developed to increase patient access to specialized care and provide regional and affiliate training of medical professionals. CDAPP has developed a document entitled Guidelines for Care, which provides evidenced-based guidelines for the application of standardized assessment and treatment protocols.//2004//

Quality of Maternity Services:
/2003/The MCH Branch supports several programs that enhance the quality of perinatal care; these include BIH, CPSP, CDAPP, and AFLP. CPSP is designed to address the needs of Medi-Cal-eligible pregnant women who are at higher risk of pregnancy complications and poor pregnancy outcomes through the provision of enhanced prenatal services.

/2004/CDAPP encourages increased screening for diabetes or gestational diabetes among high-risk ethnic populations.//2004//

The California Perinatal Quality Care Collaborative (CPQCC) is a cooperative effort by neonatal and obstetrical physicians and nurses, MCH, CMS, healthcare organizations, California business groups, and the UC Berkeley School of Public Health. It is working to develop an effective quality improvement infrastructure at state, regional, and hospital levels.

/2004/The CPQCC Data Center is partnering with Stanford University's Center for Health Policy and Research for statistical programming and other resources. In February 2003, the CMS Branch issued a formal announcement to all CCS-approved hospitals that CCS NICU annual data submission through CPQCC will be mandatory beginning in January 2004. CPQCC has also completed a study examining the association between the performance of Cesarean-sections and perinatal health outcomes in California. CPQCC's project on Antenatal Steroid Administration has entered the final stage of its improvement cycle with analysis of data and presentation of results slated for 2003.//2004//

A number of other Title V supported programs address quality issues in relation to maternal and infant care. The fourteen Regional Perinatal Programs of California (RPPC) promote access to risk appropriate quality health services to pregnant women and their infants.

To combat the serious health threat of DV, the Battered Women's Shelter Program

(BWSP) was established in 1994 as a result of legislative action.

/2004/ DV shelter organizations are encountering significant reductions in private donations and grant funding. With the input of the DV Advisory Council, the BWSP made the decision to reduce the technical assistance and training contracts to shelters from ten to one. The remainder of the funding will be redirected to direct service grantees.//2004//

Access to family planning services has been expanded by the Family PACT program, which was introduced in FY 1996-97 by the Office of Family Planning (OFP). The program promotes access to comprehensive family planning services to low-income men and women who are not otherwise eligible for Medi-Cal and have no other source of family planning coverage.

/2004/During Federal Fiscal Year (FFY) 2001-02 about 1.4 million clients, including adolescents (approximately 26 percent of clients) were served through Family PACT. DHS will continue to address teen pregnancy prevention through the AFLP program and a variety of programs in the OFP. Heightened attention to the role of adolescent males in pregnancy prevention has been promoted through OFP's Male Involvement Program.//2004//

Infants' Access to Care:
Medi-Cal and AIM also provide health insurance coverage for a comprehensive service package for infants. Medi-Cal reaches infants under one year living in households with incomes below 200 percent of FPL.
/2003/ In October, 2001, the monthly enrollment of infants in Medi-Cal was 220,779. (32) As of April, 2002, 5,993 infants less than one year were enrolled in HF. (33)
/2004/ As of March, 2003, 7,287 infants less than one year of age were enrolled in HF. This is a 22 percent increase over the past twelve months. //2004//

Infant Health Promotion
Extensive preventive screening and basic health services are provided to infants under a year of age by the CHDP program.

/2004/In FY 2000-01, approximately 520,231 infants under one year of age received health services through CHDP. After two years of decreases, the number of infants receiving health services through CHDP has increased by 4.2 percent from FY 1999-00. Of the 520,231 infants served, 60 percent had Medi-Cal coverage and 40 percent were funded by State funding sources, representing a slight increase in Medi-Cal coverage. Approximately 350,621 infants were identified as Hispanic, 51,467 as White, 29,764 as African American, 21,197 as Asian, 2,751 as Filipino, 1,687 as American Indian, 935 as Pacific Islander, and the remainder as other or unknown ethnic groups. The number of Hispanic infants served has increased by 6.2 percent from FY 1999 to 2001, reflecting the increasing Hispanic population in the State(21).//2004//

DHS has adopted a comprehensive approach to breastfeeding promotion that includes the promotion of exclusive breastfeeding initiation at birth and of prolonging breastfeeding during infancy.

/2004/Breastfeeding continues to be promoted across all programs serving pregnant women and infants. Informational materials regarding preventive care practices for women, adolescents, children, and infants are regularly disseminated to AFLP providers as well as to Cal Learn and Cal SAFE program administrators. These materials include updated information on breastfeeding, nutrition, and immunizations. The CDAPP Guidelines for Care include a chapter on breastfeeding. Patient education materials have been developed for women who breastfeed after gestational diabetes, and for those who

take insulin and breastfeed.//2004//

Birth defects remain the number one cause of infant deaths. While the causes of many congenital defects have yet to be identified, effective measures for the prevention of a significant portion of neural tube defects are known. MCH Branch activities focus on folic acid promotion during the preconceptional and prenatal periods to reduce the risk of neural tube defect-affected pregnancies.

/2002/Several programs of the MCH Branch address additional causes of infant mortality and morbidity. The Sudden Infant Death Syndrome (SIDS) Program has facilitated the SIDS Risk Reduction campaign, also known as Back to Sleep in California. /2003/The campaign has successfully reduced the incidence of SIDS by over 50 percent.

A number of newborn screening programs are conducted in California. The Genetic Disease Branch (GDB) of DHS provides newborn screening for primary hypothyroidism, phenylketonuria, galactosemia and several hemoglobinopathies to approximately 99 percent of the newborn population. A Newborn Hearing Screening Program (NHSP) is being instituted through CMS.

/2004/As of March 2003, 138 hospitals have been certified and are participating in the NHSP. According to 2001 birth certificate data, over 285,000 infants will be offered newborn hearing screening in these hospitals every year. There are also 140 certified outpatient-screening providers to perform follow-up or initial outpatient hearing screens (22).//2004//

/2003/Governor Davis signed into law AB 2427 which provides for updating and expanding California's newborn screening program. The law, which took effect on January 1, 2001, requires the DHS to investigate the feasibility of establishing a broader testing programming, including development and evaluation of expanded genetic disease testing utilizing Tandem Mass Spectrometry (MS/MS).

/2004/The CMS Branch, through local county CCS programs, has been collaborating with GDB in ensuring that infants with potentially abnormal or definitively abnormal supplemental metabolic disorder screening results expeditiously receive needed medical services at one of the 14 CCS approved Metabolic SCCs in the State. To date 41 infants have been diagnosed with a metabolic disorder through the MS/MS. The pilot project ended June 30, 2003. GDB will prepare an evaluation of the results of the pilot project over the coming year.//2004//

Preventive and Primary Care for Children

Access to Care:
The Medi-Cal and HFP provide financial access to a comprehensive package of primary and preventive services, including dental care, for California's low-income children. Medi-Cal covers children ages 1 through 5 at 133 percent of FPL, children and adolescents ages 6 up to 19 at 100 percent of FPL, and young adults 19 up to 21 years at 86-92 percent of FPL. Healthy Families provides insurance coverage for preventive and primary care to children from 0 through 18 years of age who are uninsured and living in households with incomes up to 250 percent of FPL. Monthly premiums and copayments for certain types of visits and prescriptions are required.

/2004/There were 639,909 children enrolled in HF as of March 2003. This is a 19 percent increase from the prior year(23).//2004//

The CMS Branch administers the screening and preventive component of the EPSDT Program. In California this screening and prevention component is called the CHDP Program. CHDP assures preventive services, including health assessments, immunizations, screening tests, dental screening, and referral for further diagnosis and treatment for Medi-Cal funded children up to 21 years of age. There is also a State funded component that extends these same services to children up to 19 years of age from families with incomes up to 200 percent of the FPL.

/2004/In FY 2000-01, approximately 2.2 million children received screening and health assessments through the CHDP program with 52 percent funded by Medi-Cal and 48 percent funded through State dollars. Of the Medi-Cal beneficiaries, 35 percent received services through fee-for-service Medi-Cal and 65 percent through the MCMC plans. The reporting of the number of children receiving CHDP health assessments through MCMC plans has again increased for FY 2000-2001 as plans are ensuring compliance with submission of necessary data(24).//2004//

/2004/CHDP program policies have been modified to accommodate the changes that will occur in the CHDP provider office and in the local CHDP program with the implementation of the Gateway on July 1, 2003. The training sessions to introduce CHDP providers to the Gateway are being held between April 1, 2003 and September 30, 2003 in 17 strategic locations around the state. Changes have been made to the existing CHDP provider instructions, and a new CHDP Provider Manual was issued just prior to Gateway implementation. Information about the Gateway is also available on the CHDP web site (http://www.dhs.ca.gov/pcfh/cms/chdp).//2004//

Childhood Health Promotion:
/2003/Injuries are the leading cause of mortality among children and youth. To reduce injury-related mortality and morbidity among children and adolescents, MCH's Childhood Injury Prevention Program contracts with the CIPPP, formerly known as the California Center for Childhood Injury Prevention (CCCIP), at San Diego State University.

/2004/ CHDP continues to collaborate and integrate with the CAI. The CAI, funded through June 30, 2004, has completed a report that includes outcomes for 232 children enrolled in the ATS Project for at least three months and with at least two clinic visits. The MCH and CMS Branches have participated in the California Asthma Interagency Work Group, a collaborative between DHS and California Environmental Protection Agency to share information and serve as a forum for collaboration to address asthma in California. CHDP is also actively involved with Childhood Obesity Education, school health activities, and the development of the CHDP Gateway.//2004//

Services for Children with Special Health Care Needs:
The CMS Branch administers the CCS program that provides case management and payment of services for CSHCN. The program authorizes medical and dental services related to the CCS eligible condition. Additionally, it establishes standards for providers, hospitals, and special care centers for the delivery of care in tertiary medical settings and in local communities, and provides physical and occupational therapy and medical case conference services at selected public school sites for children with specific medically eligible conditions.

/2003/ The CCS Medical Therapy Program (MTP) directly provides physical and occupational therapy services to children with CCS eligible conditions. There is no financial eligibility requirement. There currently are 104 Medical Therapy Units located on public school campuses throughout California.

/2004/ Over 22 new Medical Therapy Units (MTUs) or therapy satellites are currently

undergoing remodeling, in the process of construction, or in the design phase throughout Southern California. These new MTUs will be ready for occupancy in 2003 to 2008. The facility expansion is necessary to accommodate the overcrowding at existing MTUs and to extend outpatient services to communities with new school construction. //2004//

/2004/ The estimated caseload for CCS in FFY 2001-02 was 165,710. This is a 5.1 percent increase from the prior year. Approximately 75 percent of these children were enrolled in Medi-Cal and 8.5 percent were enrolled in HF. CHDP providers continue to facilitate referrals to CCS of children with CCS eligible medical conditions or potentially CCS eligible conditions.//2004//

/2004/ Thirty-one county health departments fully administer their own CCS program and are designated as independent counties. The remaining 27 dependent counties share the administrative and case management activities with CMS Branch Regional Offices located in Northern and Southern California. The CCS program is responsible for case managing the CCS eligible condition for Medi-Cal beneficiaries and authorizes Medi-Cal reimbursement for medical and dental services related to the CCS condition, including EPSDT supplemental services. CCS also case manages the CCS eligible condition for children enrolled in HF. Through a system of CCS-approved SCCs, CCS provides access to quality specialty and subspecialty providers for CSHCN. The SCCs are located in the outpatient departments of tertiary care hospitals and use multidisciplinary teams to address health needs and provide coordinated care for CCS beneficiaries.//2004//

/2004/ The CCS program has structured a system of regional affiliation among the 114 CCS approved NICU, to assure that infants have access to appropriate specialty consultation and intensive care services throughout the state. CCS approved NICUs are designated as Intermediate, Community, and Regional NICUS. NICUs that provide basic level intensive care services to infants in their communities are required to have established affiliations with NICUs that provide more extensive services, to facilitate obtaining consultation and needed patient transfers. The CCS approval process denotes the level of patient care provided in each NICU and verifies that the cooperative agreements are in place. In June 2001 the CPQCC initiated annual NICU data reporting to CCS for the first cohort of participating nurseries. Annual NICU reporting is required for continuing CCS approval and reporting through the CPQCC will facilitate data submission and analysis and improve reporting accuracy. In February 2003, the CMS Branch instructed all CCS-approved hospitals that CCS NICU annual data submission through CPQCC will become mandatory beginning in January 2004. The web-based report for 2001 has been completed and is available on-line. Data trainings for new CPQCC member hospitals are being scheduled. //2004//

The CMS Branch has two programs that address the needs of high-risk infants. The first allows infants that are discharged from CCS approved NICUs to be followed in NICU High Risk Infant Follow-up clinics. Three multidisciplinary outpatient visits are authorized by CCS during the first three years of life to identify problems, institute referrals, and monitor outcomes. Visits include a comprehensive history and physical examination, developmental testing, and ophthalmologic, audiologic, and family psychosocial evaluations. The second program, the Medically Vulnerable Infant Program (MVIP), has used a network of community-based contractors to provide home-based services to high risk infants from NICUs and their families. Services have been provided to infants up to three years of age. Infants are eligible for the MVIP program, if they have required medical care in a CCS approved NICU, are at risk of developing a CCS eligible condition, and were premature or had a defined, serious neonatal health problem.

/2004/ A total of 12 contractors including hospitals, community-based organizations and universities were awarded contracts to participate in the MVIP from July 1, 2000 to June

30, 2003. These contracts have been extended for two more years until June 30, 2005. As of April 9, 2003, 2,739 infants participated in MVIP and the program had made 25,118 home visits. At this time there were 1,501 active cases, all of whom had a medical home.//2004//

The Genetically Handicapped Persons Program (GHPP) provides case management and funding for medically necessary services for people with certain genetic conditions including cystic fibrosis, hemophilia, sickle cell disease, and neurologic and metabolic diseases. Most GHPP clients served in this program are adults. However, approximately 10 percent of the program enrollment are children under 21 years of age. The GHPP will serve eligible children with higher family incomes that make them ineligible for the CCS program.
/2004/ There are currently 1666 clients enrolled in GHPP. Hemophilia remains the most common diagnosis with 27 percent of the caseload. Clients with cystic fibrosis, sickle cell disease, Huntington's Disease, and Friedreich's Ataxia respectively make up 23, 22, 9, and 7 percent of the GHPP caseload(25). //2004//

Rehabilitation services to SSI beneficiaries under the age of 16:
SSI beneficiaries with a CCS medically eligible diagnosis, who meet the CCS residential eligibility criteria, are served by the CCS program. If physical and/or occupational therapy are needed, they can be provided in the CCS Medical Therapy program. Children on SSI who have mental or developmental conditions are served by the Departments of Mental Health, Developmental Services (regional centers), and Education.
/2004/ During FY 2001-2002, CCS has received approximately 1750 referrals of SSI beneficiaries for possible CCS eligible conditions(26). Of these, approximately half are medically eligible for CCS. //2004//

Provide and promote family-centered, community-based coordinated care for CSHCN:
SCCs and hospitals that treat CSHCN and wish to become CCS-approved must meet specific criteria for approval. One of the criteria used in evaluation involves family-centered care (FCC). During the center review, the following are considered: the level of parental involvement in treatment decision making; sharing of reports with families; the degree of parent/patient involvement in advisory committees that set policies and procedures; and availability of healthy sibling and parent visiting. Following the review of the SCC, the CMS Branch sends a follow-up report to the facility with FCC recommendations.

/2004/ The CCS program has a longstanding history of facilitating FCC and services for families of CSHCN. Many years ago the program recognized that families often needed assistance to travel to their designated SCC, and in some cases, to stay overnight. Also, CSHCN at times require hospitalization, electively or emergently, often at a distance from their homes; their families may also need assistance with travel, lodging and meals. County CCS programs budget for maintenance and transportation expenses for CSHCN and their families. County CCS programs also work with hospitals and community agencies that contribute to expenses for family maintenance and transportation.//2004//

/2004/ County CCS programs also work with SCCs, hospitals, and families to cluster appointments so more than one appointment can occur on the same day or over two days, and in this way assist families with arranging time away from home and travel time that can be exhaustive. CCS staffing standards now allow a parent liaison position for each county CCS program. Four counties have hired a Parent Liaison thus far. In addition, CCS has requested that the CISS (Community Itegrated Services System) Project develop a guide for county CCS programs to conduct training on FCC. This guide is currently under development. //2004//

/2004/ The CMS Branch has been collaborating with Family Voices in a two-phase project. In the first phase, completed at the end of 2002, approximately 24 letters/documents used in the CCS application and program eligibility process were revised to make them more family-centered. Several new letters were created. In the second phase of the project, approximately 30 CCS program letters and materials related to continuing eligibility will be reviewed by Family Voices and revised to ensure they are easily understood by families and that families are fully informed of CCS services and procedures.//2004//

Provide transitioning services to CSHCN:
The CMS Branch recognizes the importance of transitioning care for CSHCN from pediatric to adult services. Standards for beginning transition services at age 14 years are being added to the standards for the outpatient SCCs. An instruction letter will be sent to county CCS programs on the subject of FCC and will also discuss transitional issues. During site reviews of new SCCs and county CCS programs, transition issues are emphasized as important for the future delivery of medical care and services to the CSHCN. During both types of reviews, staff is made aware of the availability of transitioning resources such as the California Department of Rehabilitation and the Centers of Independent Living to assist youth in transitioning to independence.

/2004/Within the past year, county CCS programs in the San Francisco Bay Area have participated in training on the transition of services from pediatric to adult. Representatives from hospitals and community agencies such as Support for Families were present. The Alameda County CCS program has been very active with their transition planning process which was presented at the training. Also, state and county CCS staff this past year attended a UCSF and DDS sponsored workshop that focused on transition services. There have been transition-planning activities in Southern California. The MTP in Ventura County is actively involved with transition projects. Representatives regularly attend and participate with the Special Education Local Planning Areas (SELPA) Interagency Coordinating Transition Council and there is coordinated SELPA training on the process of transitioning to adulthood. In Kern County, the MTP Physiatry Clinic emphasizes referral for transitioning services for older children who have sustained spinal cord injuries, traumatic brain injuries, vascular accidents and related disabilities. In Santa Barbara County, there is a Transition Committee of CCS staff that receives input from CCS parents, young adult clients, and the Family Support Center to assess and develop ways to infuse the concept of transition into all CCS services and functions. The committee organizes in-service training and presentations for CCS staff. Current and former CCS clients attend meetings to share their experiences. In addition, the CMS Branch is arranging a workgroup of CMS Branch staff, county CCS representatives, a parent liaison, and representatives from community-based organizations to develop written policy and policy implementation guidelines for transition planning for older children.//2004//

C. Organizational Structure

Please see Attachment updated organizational charts. And see below for url links to our Primary Care and Family Health PCFC Division and California Executive Branch CA EXEC organizational charts:

PCFC
http://admin.int.dhs.ca.gov/orgcharts/pdf/pcfh.pdf

CA EXEC
http://www.cold.ca.gov/Ca_State_Gov_Orgchart.pdf

MCH and CMS are located in the California State health agency, the Department of Health Services (DHS). DHS is one of 13 departments within the California Health and Human Services Agency. Mr. Grantland Johnson is the Secretary for Health and Human Services, which is a cabinet-level position reporting directly to Governor Gray Davis. The DHS Director is Diana Bontá, RN. DrPH.

The MCH and CMS Branches are in the Primary Care and Family Health (PCFH) Division of the DHS. The other Branches in PCFH are: Office of Family Planning; Women, Infants and Children (WIC) Supplemental Nutrition; Genetic Disease; and Primary and Rural Health Care Systems. The Deputy Director of PCFH is Tameron Mitchell, RD, MPH. The Acting Chief of the MCH Branch is Gilberto Chavez, MD, MPH and the Chief of the CMS Branch is Maridee A. Gregory, MD. The MCH and CMS Branches have joint responsibility for carrying out the Title V functions.
/2002/ In May 2001, Dr. Chavez was named as the Chief of the MCH Branch.
/2003/ Dr. Chavez announced he will be returning to CDC on September 1, 2002. Plans to fill the position are pending.
/2004/ In February 2003, Catherine Camacho was named as the new Deputy Director of PCFH. Susann Steinberg, MD was appointed as the Acting Chief of the MCH Branch following the move of Dr. Gilberto Chavez to CDC in September 2002. //2004//

DHS is designated to administer the MCH program by the California Health and Safety Code Div. 106, Part 2, Chapter 1, Article 1 Sections beginning with 123225. The CCS program is authorized by the Health and Safety Code Division 106, Part 2, Chapter 3, Article 5, Sections 123800-123995. The Genetically Handicapped Persons Program, which provides services to individuals with certain genetic conditions, is authorized by the Health and Safety Code Division 106, Part 5, Chapter 2, Article 1, Sections 125125-125180. The Child Health and Disability Prevention program, California's preventive healthcare program for children, is authorized by the Health and Safety Code Division 106, Part 2, Chapter 3, Article 6, Sections 124025-124110 and by Division 103, Part 3, Chapter 1, Article 1, Section 104395.

 View Attachment

D. Other MCH Capacity

Maternal and Child Health Branch:
Since February 2000, Dr. Chavez, MD, MPH has been Acting MCH Branch Chief. In February 2001, Les Newman was named to the position of Assistant Chief of the Maternal and Child Health Branch. He has over twenty years working in leadership positions in California government and was previously Operation Section Chief within the MCH Branch.
/2002/ In May 2001, Dr. Chavez, MD, MPH was named the MCH Branch Chief.
/2003/ Dr. Chavez, MD, MPH will be leaving as MCH Branch Chief on September 1, 2002.
/2004/ Susann Steinberg, MD was appointed the Acting Chief of the MCH Branch. Dr. Steinberg is Board Certified in Family Practice as well as Preventive Medicine and has an MBA. She is also Chief of the Program Policy Section in the MCH Branch. //2004//
/2003/ The MCH Branch staff includes senior consultants in a variety of clinical, public health, and scientific disciplines. Emeterio Gonzalez, M.D. (PHMO III) is a Board Certified Obstetrician and Gynecologist who serves as a medical consultant to the Branch. Robert Bates, M.D, MPH is a part-time Medical Consultant board certified in Pediatrics with over twenty years of local public health experience. Eileen Yamada, M.D. (PHMO III) is a board-certified Pediatrician and serves as the MCH Pediatric Consultant and State Adolescent Health Coordinator. Katherine Heck, M.P.H, is a Health Statistician with the National Center for Health Statistics, CDC. Sharon Durousseau, M.D., M.P.H. is

an Epidemic Intelligence Service Officer (EIS) with CDC. Rhonda Sarnoff, Dr.P.H., serves as the Title V Coordinator.
/2004/ In 2003, the staff previously responsible for the Title V report, Rhonda Sarnoff, Dr.PH, Katherine Heck, MPH and Sharon Durousseau, MD, MPH, left the MCH Branch. The MCH Branch was able to recruit two excellent replacements: Holly Huffer, Ph.D. the new Title V Principal Author and Gretchen Caspary, Ph.D., MBA the Coordinator for the Title V Five-Year Needs Assessment. //2004//

The MCH Branch is divided into five sections: Program Policy; Epidemiology and Evaluation; Domestic Violence; School Health Connections; Operations.
/2004/ The MCH Branch has been consolidated into three sections: Program Policy; Epidemiology and Evaluation; and Operations. DV and School Health Connections are now programs under the Programs and Policy Section.//2004//

Epidemiology and Evaluation Section: The section provides program information for monitoring MCH program implementation, evaluating program effectiveness, and policy development. Program and population-based data are analyzed to support California's application for Federal Title V Grant Funds and Needs Assessment. They also provide assessment and surveillance information for use in program related research, program policy planning, and allocation of resources.
/2002/Gwen Nakagawa, Research Manager II, was named Acting Chief in May 2001.
/2003/Ellen Stein M.D., M.P.H., was named Section Chief.
/2004/In May 2003, Shabbir Ahmad, D.V.M., M.Sc. (Hons.), Ph.D., was named Acting Section Chief. The section is organized into two research units comprised of 22 research and support staff.//2004//

Operations Section: Les Newman is Section Chief. This Section assumes the administrative functions for the branch, including: fiscal forecasting, budget related work, legislative liaisons, managing over 300 contracts, auditing functions, maintaining the infrastructure needs of the branch, and working with Department of Finance and other control agencies.
/2002/ Nancy Smith is Section Chief. She has held management positions in the Department of Health Service's Budget office helping plan and oversee the Department's $28 billion budget.
/2004/ Nancy Smith is Section Chief. The section has two units: the Contract Management and Policy Unit (12 staff) and the Contract and Fiscal Management Unit (14 staff).//2004//

Programs and Policy Section: The section chief is Dr. Terrence Smith (PHMO III). This Section coordinates the implementation of standards of care for pregnant women under the CPSP, RPPC, FIMR, SIDS, CDAPP, BIH, and AFLP. Program consultants develop standards and provide consultation and technical assistance to local MCH jurisdictions and other organizations.
/2002/ The section chief is Dr. Willie Parker (PHMO III).
/2003/ The section chief is Dr Susann J. Steinberg (PHMO III).
/2004/ Dr. Steinberg remains as section chief while also serving as Acting Branch Chief. Perinatal Health units are supervised by a Nurse Consultant Supervisor and consist of 16 staff members. The Child and Adolescent Health Unit with 5 staff members is supervised by a Nurse Consultant Supervisor III . Responsibility for the provision of consultation and technical assistance to the 46 agencies who provide AFLP services (37 of these also provide ASPPP services) was centralized in this unit during the past year.//2004//

Domestic Violence Section: This section is headed by Ms. Carol Motylewski-Link.
/2002/ The section has a staff of seven and is currently under the leadership of Mr. Joseph Perez.

/2003/ The section has a staff of six.
/2004/ As of July 2002, the DV Section was incorporated into the Program Policy Section. The DV Program consists of a Nurse Consultant III, Suzie Fatheree, as an acting manager and 6 staff. The DV Program currently has 146 grants compared with 155 grants from the previous year. State budget reductions have reduced statewide technical assistance and training contracts from ten to one.//2004//

School Health Connections: This section is headed by Nancy Gelbard, MS, RD, a Health Program Specialist II. The Section has a total of five staff.
/2002/ This section remains under the leadership of Nancy Gelbard, MS, RD.
/2003/ The Section has a total of eight staff and is lead by Nancy Gelbard, MS, RD.
/2004/ SHC did not receive continued CDC funding and the 25 contracts for HF/Medi-Cal school outreach ended June 30, 2002 due to lack of State funds. The remaining 6 foundation funded contracts will be completed on June 30, 2003. SHC is now under the leadership of Suzie Fatheree, Nurse Consultant and Manager of the DV Program and has 1 staff member. This coming year will be used to develop program priorities.//2004//

Children's Medical Services (CMS) Branch:
Maridee A. Gregory, M.D., board-certified pediatrician, implemented the merger of CHDP and CMS Branches in 1992 and remains as Branch Chief. She has been with DHS since 1981, serving in the capacity of Chief of the MCH Branch, Acting Deputy Directory of Public Health, Chief of the CCS Branch, and currently as Chief of the CMS Branch. Elisabeth H. Lyman, MPH, Assistant Branch Chief, has been with DHS since 1978, and in that time has served in a variety of policy and administrative positions. Ms. Lyman has a M.P.H. in Medical Care Organization.
/2004/ Ms. Lyman has been appointed Assistant Deputy Director for PCFH Division. The CMS Branch is currently recruiting an Assistant Branch Chief. //2004//

The CMS Branch is organized into four sections.
/2002/ The CMS Branch has been re-organized and is now composed of five sections:

Program Standards and Quality Assurance (PSQA) Section:
The PSQA section is responsible for the development of regulations, program policies and procedures, and provider standards for both the CHDP and CCS programs; development and maintenance of the NHSP; development of policies and procedures to implement Medi-Cal managed care, the HFP, the Health Care Program for Children in Foster Care and the Children's Asthma Program; provision of pediatric consultation to the Medi-Cal program and other DHS programs. The Section also reviews and approves all requests for organ transplants for children funded by CCS and Medi-Cal.
/2002/ Marian Dalsey, M.D., M.P.H., board certified pediatrician, has resumed the position of section chief, which she had held until 1999.
/2003/ The Children's Asthma Program reports directly to the Branch Chief. PSQA is divided into Medical Program Policy and Standards with eight staff and Program Planning and Development with ten staff.
/2004/ No changes to the Section. //2004//

Program Operations Section (POS):
Jean Whittiker, P.H.N., B.S.N., M.S., is the Chief of the Program Operations Section since 1996.
The POS is responsible for planning, implementing, and monitoring the CCS and CHDP programs, and GHPP. Professional staff provide pediatric medical expertise and consultation in medicine, nursing, PT/OT, dentistry, nutrition, audiology, public health social work, and educate providers, State and local agencies, and the public. There are 45 permanent positions in this section, divided between the central office in Sacramento and the regional offices. Each regional office has a Medical Director and provides direct

case management services for CCS-eligible children in dependent counties, consultation to the independent CCS programs regarding medical management, and consultation to local CHDP programs regarding program operations. The POS is implementing the Health Care Program for Children in Foster Care.
/2002/ There are 44 staff positions.
/2003/ GHPP is the responsibility of the Program Case Management Section. POS is responsible for oversight and monitoring of the MTP. POS has responsibility for review and approval of hospitals and SCCs.
/2004/ The Program Manager of the POS, Jean Whittiker, retired from state service in 2003. At the time of the writing of the Title V Plan, the selection process to replace her was underway. The section has 41 positions. //2004//

Program Case Management Section:
The Program Case Management Section manages the GHPP and the Children's HIV programs and carries out most of the dependent county case management for the Northern California region. The section has 48.5 positions and is under the direct supervision of Dr. Gregory.
/2002/ Karlette Winters, M.D., is chief of the Case Management section. Dr. Winters is board certified in pediatrics and ophthalmology. The section has 60.5 positions.
/2003/ The Section has three units. The Case Management Unit provides CCS case management for 21 dependent counties. The GHPP Unit provides case management for GHPP clients. The Provider Services Unit is responsible for the enrollment of CCS, GHPP, and CHDP program providers; approving CCS paneled providers; and maintaining records of CCS/GHPP approved facilities and SCCs. There are 56.5 positions.
/2004/ The Case Management Unit is now referred to as the CCS Sacramento Regional Office (SRO). There are 52.5 positions. //2004//

Program Support Section (PSS):
The section chief is Irvin B. White. PSS has 25.5 permanent staff, are organized into five units.
/2002/ The section has 21.5 positions.
/2003/ PSS is organized into three units: Data Analysis, Research, and Evaluation (DARE); Clerical Support; and Administration.
/2004/ PSS is under the direction of Erin M. Whitsell. The PSS has 18 permanent staff with responsibility for budget planning and fiscal management of CMS funds; supervising and prioritizing expenditure of funds; data analysis and research; negotiating and preparing contracts and grants; personnel and position management; business services; and clerical support. //2004//

Information Technology Section (ITS):
This new section headed by Byron Roberts has 10 staff and is responsible for all aspects of information technology support for the CMS Branch and for the CMS case management and data system(CMS Net).
/2003/ ITS is organized into Information Systems with 10 staff and IT Support with five staff.
/2004/William White, B.A., is the section chief; 12 State and 5 contract positions.//2004//

E. State Agency Coordination

DHS is one of thirteen entities within the Health and Human Services Agency. DHS encompasses a number of Divisions with responsibilities that are relevant to Title V activities and which coordinate with the programs of the MCH and CMS Branches within the PCFH Division. These include: the Office of Women's Health; Medical Care Services (Medi-Cal); Prevention Services (site of Immunization and Childhood Lead Poisoning Prevention Branches); Health Information and Strategic Planning; and the Office of

Multicultural Health.

Inter and intra agency collaboration is vital for meeting the needs of all children and particularly CSHCN. CMS has numerous collaborative relationships with State and local public health agencies, in both the public and private sectors, as well as working relationships with organizations such as local foundations, medical professional associations, coalitions and children's advocacy groups.

/2004/ The MCH and CMS Branches collaborate with WIC in a variety of areas including: the improvement of prenatal care, linkages between MCH and WIC data files, oral health, childhood injury prevention, and breastfeeding. In addition, both Branches collaborate with WIC on obesity prevention. //2004//

/2003/ School Health Connections has played an important role in demonstrating the potential impact of building ongoing collaboration between DHS and the Department of Education (DOE) on reaching their shared goal of improving the health status and academic success of California's school-age children.
/2004/As a result of the loss of the CDC and private foundation funds, SHC will be reprioritizing program objectives. However, interagency collaboration, especially with CDE, will continue to be a priority. //2004//

Department of Developmental Services (DDS):
Early Start: The CCS program and Medi-Cal provide medically necessary services that fulfill the early intervention needs of eligible infants and toddlers served by the Early Start Program. Through a CMS Branch liaison and CMS physician participation on the Interagency Coordinating Council and Health Services Committee, the CMS Branch maintains ongoing communication with the lead agency (DDS), the Department of Education, regional centers, local education agencies, community-based organizations, advocates, parents, families, and other interested parties involved with early intervention.

/2002/ There is no longer a CMS/DDS funded liaison position but CMS continues to maintain active collaboration with DDS through participation of a CMS physician on the Interagency Coordinating Council (ICC) and the ICC Health Systems Committee.
/2004/CMS Branch and MMCD collaborate with DDS to develop an interagency agreement for the Early Start Program. The collaborating parties have jointly drafted an agreement that establishes a common set of working guidelines and procedures to support positive collaboration between the agencies in coordinating early intervention services for children aged 0-3 years. The draft agreement is under review by both departments. NHSP worked with DDS and the CDE to ensure that all infants identified with hearing loss are referred to the Early Start program.//2004//

California Department of Education (CDE):
Medical Therapy Services: The CCS program has been collaborating with the Departments of Education and Mental Health to promulgate interagency regulations defining respective responsibilities in delivering medical therapy services to students eligible for special education.
/2003/ The MCH Branch works closely with CDE on the SHC Program. The two Departments collaborated to develop the infrastructure to support coordinated school health. Working with a statewide planning body, SHC produced the report, "Building Infrastructure for Coordinated School Health: California's Blueprint"42 which identified the goals and actions required for coordinated school health.
/2004/ NHSP and CDE joint activities include developing statewide standards for parent-infant curriculum and methodology-neutral language assessment of infants with hearing loss to be used in Early Start programs. The MCH Branch continues to work closely with the CDE in SHC to develop the infrastructure to support coordinated school

health.//2004//

Department of Social Service (DSS):
Children in foster care: California has been selected by the National Academy for State Health Policy as one of five states to improve the health services for children in foster care through collaboration with the Departments of Social Services and Mental Health. The CMS Branch, in conjunction with DSS, worked with the County of San Francisco Health Department and University of California Los Angeles (UCLA), School of Public Health, to develop health care guidelines for children in foster care. These activities served as the basis for the new Health Care Program for Children in Foster Care (HCPCFC). /2002/ The HCPCFC is active in 55 health jurisdictions and remains a major collaborative effort between DSS and CMS.
/2003/ HCPCFC, has established a process through which PHNs consult and collaborate with foster care team members to promote and coordinate access to comprehensive preventive health and specialty services. PHNs work with social workers and probation officers to identify and coordinate health care services for each child.
/2004/ Collaborative efforts between DHS and DSS have expanded to include the MMCD. The CCMS Branch and DSS have contributed to the MMCD's Task Force on CSHCN to develop basic expectations and desired outcomes for CSHCN enrolled in California's MCMC plans. CMS Branch also collaborates with DSS on SSI referrals. In the past 11 years, the CMS State Social Worker Consultant has processed over 26,000 referrals to CMS of children with SSI. Working together over the past 10 years, the social worker at CMS and a designated social worker at DSS have expedited problem claims, helping approximately 1000 clients obtain the benefits for which they were eligible. //2004//

DHS, Childhood Lead Poisoning Prevention (CLPP) Branch:
Lead Poisoning Prevention: The CMS Branch, through CHDP, provides lead screenings for children. CCS covers the cost of the evaluation and treatment of serious lead poisoning cases. Because of concerns about inadequate identification of low income children with lead poisoning, CHDP and CLPP have developed a new approach to lead screening that considers all low income children to be at risk and requires blood lead screening in this population.
/2003/ The CMS and CLPP Branches are continuing to work together to inform the CHDP program health assessment providers of their responsibilities with respect to blood lead testing and lead counseling. Both Branches issued provider information notices restating policy and informing providers of new CHDP code numbers for billing, reporting lead screening and lead counseling41.
/2004/ CMS and CLPP Branches are issuing provider information that updates the CHDP Health Assessment Guidelines on: 1) collection of specimens for blood lead analysis; 2) management guidelines; and 3) anticipatory guidance related to lead exposure. //2004//

DHS, Immunization (IZ) Branch:
Childhood immunizations: The CMS Branch actively collaborates with the Immunization Branch and its Vaccines For Children program by providing vaccinations through the CHDP program.
/2004/ Collaboration between these two branches continues with the recent addition of PediarixTM as a VFC covered immunization and a CHDP vaccine benefit. CMS Branch collaborates with the IZ Branch with representation on the Statewide Immunization Information System (SIIS) Executive Consultative Committee. This committee provides oversight and support for California's statewide immunization registry network. When fully implemented this computerized system will track patient immunization records and help providers to potentially immunize all California children and adolescents. //2004//

DHS, Medi-Cal Managed Care Division (MMCD):

/2003/ Memoranda of Understandings (MOUs) between county health plans and CHDP and CCS programs are mandated by DHS. Each local program coordinates with individuals from the plan and maps out a procedure for working together. DHS liaisons from the Medi-Cal Managed Care Division and the CMS Branch meet together to ensure that these MOUs are effective working documents.
/2004/ DHS liaison activity takes place within the HF. At the state level, the CCS program's liaisons and the liaison from the Managed Risk Medical Insurance Board (MRMIB), which administers HF, rotate quarterly meetings throughout the state for medical plans. A separate meeting is held for dental plans as CCS dental and orthodontic services are carved out of the dental plans. Ad hoc subcommittees composed of members from the CCS program, MRMIB, and the MCMC plans have successfully worked together on provider training and solving program issues.//2004//

DHS, Genetic Disease Branch:
Newborn Screening Program: CCS provides services for conditions identified on newborn screening tests and develops standards for and approves Special Metabolic and Endocrine Centers, where these children are treated. The MCH Branch is working with GDB on a campaign to educate women about pre-pregnancy folate use.
/2004/ The GDB currently has a staff of 114 and a budget of over $60 million. Direct services are provided by private providers under contract for newborn, prenatal, and Tay Sachs screenings. GDB enforces quality standards via contract requirements or by regulations; in addition to the screening program, GDB also monitors quality standards for Rh testing, genetic counseling and mandated laboratory reporting of cytogenetics. GDB also engages in research projects to develop new or improved tests.//2004//
/2003/ In September, 2000, Governor Davis signed into law AB 2427 which provides for updating and expanding California's newborn screening program. The law, which took effect on January 1, 2001, requires the DHS to investigate the feasibility of establishing a broader testing programming, including development and evaluation of expanded genetic disease testing utilizing MS/MS. The CMS Branch is working with GDB to ensure that infants with potentially abnormal results from MS/MS testing receive diagnostic evaluations at one of the CCS approved Metabolic SCCs in the state.
/2004/ This statewide MS/MS pilot project ended June 30, 2003. Over 320,000 infants were screened and at least 41 infants were diagnosed with metabolic disorders. Testing was offered in 60 percent of hospitals with maternity services; there was a 90 percent acceptance rate for this expanded optional screening, regardless of race/ethnicity. The CMS Branch has ensured that infants with potentially abnormal screening results receive diagnostic or treatment services in any of 14 CCS approved Metabolic SCCs around the state. Over 425 infants have been referred to SCCs. At the conclusion of the pilot project, over 100 cases with suspicious results continue to be evaluated. GDB will prepare an evaluation of the results of the pilot project over the coming year. //2004//

DHS, Birth Defects Monitoring Program:
Birth defects: The CMS Branch and the Birth Defects Monitoring Program share some mutual target populations. CMS continues to collaborate with Birth Defects Monitoring, particularly in the area of cerebral palsy.
/2002/ The cerebral palsy project is no longer being carried out.
/2004/Coordination with the California Birth Defects Monitoring Program (CBDMP) is essential in DHS's efforts to reduce birth defects. CBDMP is recognized worldwide for the quality and scope of its birth defects surveillance data and for the quality of its research to identify causes of birth defects. For example, CBDMP discovered that folic acid taken at the time of conception prevents several types of birth defects. This finding, consistent with other research results, was the basis for the federal Food and Drug Administration's decision to fortify grains with folic acid. Recently, CBDMP found that tobacco smoking during pregnancy is associated with development of cleft lip and palate. This finding has been used by First Five in their smoking cessation campaigns. The annual cost savings

from the folic acid and smoking cessation strategies is estimated at $100 million. Title V funds are used to partially fund birth defects surveillance in Los Angeles, Orange, San Diego, San Francisco, and Santa Clara Counties. Additionally, Title V funds are supporting the development and on-going maintenance of the CBDMP website, which has been a fundamental tool for communicating the results of birth defects research and raising awareness about the issue of birth defects and the importance of research in identifying causes of birth defects.//2004//

California District of the American Academy of Pediatrics (AAP):
The CMS Branch coordinates efforts with the AAP to develop guidelines for local CCS programs regarding the definition of a “medical home” and authorization of pediatricians and other primary care providers to provide these services for CSHCN. The AAP has also been actively involved in planning the NHSP.
/2002/ CMS and the AAP are collaborating with CLPP on lead screening issues.
/2003/ AAP is actively working with the CMS Branch in the development of the CHDP program as a gateway to Medi-Cal and Healthy Families Enrollment.
/2004/ Each of the four California Chapters of the AAP has identified a Chapter Champion for Newborn Hearing Screening who has worked with the CMS Branch on implementation of NHSP. The four Chapter Champions and the Executive Director of the AAP met with NHSP staff in January 2003 to discuss program, access, and reimbursement issues for children with hearing loss. The NHSP continues to partner with the AAP in physician education and outreach activities. AAP advisory group providing input on the development and implementation of the CHDP Gateway. AAP is planning to inform member pediatricians of the Gateway through newsletters and website up-dates. //2004//

California Association of Neonatologists (CAN) and University of California Berkeley School of Public Health:
The CMS and MCH Branches are working with these groups on a perinatal and neonatal morbidity and mortality reporting system that will provide valuable information regarding quality of care and serve as a basis for quality improvement in participating hospitals (CPQCC).
/2002/ CCS has been providing technical assistance to CAN on issues related to patient CCS eligibility and provider claiming.
/2003/ The CMS Branch continues to provide technical assistance to CAN on services in CCS approved NICUs and on the NHSP.
/2004/ CAN and the CMS Branch continue to work closely on issues related to NICU and NHSP. The NHSP has provided technical assistance and consultation to many members of CAN. Representatives from the NHSP staffed an information booth at the annual CAN meeting in March 2003.//2004//

California Medical Association and California Health Care Association:
The CMS Branch continues to interact with these two groups on issues concerning providers for CSHCN and on services provided through CHDP.
/2003/ The CMS Branch interacts on an ongoing basis with these key health care provider organizations on issues concerning services for the CSHCN population and CHDP services, including procedures for service authorizations, claims adjudication, provider reimbursement, and provider enrollment and credentialing.
/2004/A CMA representative participates on the CHDP Gateway Advisory Group. This Group provides assistance in identifying critical issues that need to be addressed in the implementation of the CHDP Gateway program.//2004//

County Health Executives Association of California (CHEAC) and California Conference of Local Health Officers (CCLHO):
The CMS Branch works with these associations on issues related to county program

operations for CSHCN and preventive health services for children. MCH Branch leadership participates in ongoing activities and committees of the CCLHO.
/2002/ The CCLHO is collaborating with CMS on issues pertaining to the CMS Net Data system.
/2003/ Both organizations were actively involved in the development of the CHDP Gateway concept. Another issue of interest was determination of residential eligibility for children for the CCS program. Current policy required a re-evaluation in response to a challenge from a legal advocacy organization. County health departments are responsible for paying 50% of the cost of care for those children not enrolled in either Title XIX or Title XXI.
/2004/The CHEAC and CCLHO are represented on the DHS CHDP Gateway Advisory Group.//2004//

California Children's Hospital Association:
The CMS Branch has ongoing collaboration with this organization on numerous issues, including standards for managed care compliance, the Newborn Hearing Screening Program, and maintaining access to specialty health care services for children.
/2003/ The Children's Hospitals are critical and major providers of services to children in the CCS program. CMS has collaborated with California Children's Hospital Association (CCHA) on multiple issues including trainings on compensation, a "Best Practices Seminar", and technical assistance and consultation on many areas of concern. Children's Hospitals are experiencing budget shortfalls. CMS is working with the hospitals to increase revenues by reducing administrative costs by streamlining CCS referral, authorization, and billing processes and accelerating payment.
/2004/ The CMS Branch has collaborated with the CCHA and California Medical Assistance Commission (CMAC) on developing hospital payment and policy for FDA approved inhaled nitric oxide therapy in neonates. This therapy is used for the treatment of term and near-term (>34 weeks) neonates with hypoxic respiratory failure associated with clinical or echocardiographic evidence of pulmonary hypertension.//2004//

Professional Organizations:
The CMS Branch has collaborated with several professional and advocacy organizations this past year to improve working relationships and recruitment of their providers. Included are the California Association of Orthodontists, the California Orthopedic Surgeons Association, the California Association of Home Health Agencies, and the Hemophilia Foundations.

Managed Care Plans:
CMS participated in several conferences sponsored by California Managed Care plans. The purpose of the conferences was to educate physician provider networks and to establish more efficient working relationship.
/2002/ The California HealthCare Foundation, Family Voices and the Children's Regional Integrated Service System (CRISS), are working with CMS on a major effort to provide medical homes to CSHCN. The California HealthCare Foundation is also working with UCSF to support parents in family resource centers to work on CCS related activities. Family Voices and the San Francisco County Health Department are collaborating to develop family centered materials for the CCS program.
/2003/ The CMS Branch Chief is a member of the Steering Committee of the California Medical Home Project, funded by the California HealthCare Foundation. The project will support seven local, community-based coalitions and will promote the development of new and improved systems, designed by stakeholders, to improve access to medical homes for CSHCN.
/2004/Two pilot projects were implemented to solve statewide operational problems that occur with the carve-out of CCS services in Medi-Cal and HF managed care plans. The first project addresses duplicate documentation required by the CCS program for a

speciality provider to become a CCS provider. The health plan is responsible for provider relations and the credentialing of providers. CCS accepts the plan's credentialing review and processes a limited application more quickly. By expediting the enrollment process for these providers, the pilot project hopes to increase physician specialty participation and maintain continuity of care within the plan and the local CCS program. The second pilot project is a claim dispute resolution process between CCS and the health plan so that the providers are not penalized as the payers worked out the responsibility for the claim. The goal is to pay providers upon completion of services and resolve disputed claims between the program and the plan after services are rendered. //2004//

F. Health Systems Capacity Indicators

#1
/2004/ Health System Capacity Indicator 1 –HSCI 1(formerly Core Health Status Indicator CHSI #1), is the rate per 10,000 for asthma hospitalizations among children less than five years old. In 2001, the child hospitalization rate due to asthma was 25.8 per 100,000, a decrease from the 2000 rate of 31.5. Although rates for asthma fluctuate fairly widely in California, there is an increasing rate from 1997 to 2000. This is consistent with national increases in prevalence between 1980 and 2000 [1] but contrary to the Healthy People 2010 objective to reduce the rate [2]. [1] CDC. Self-Reported Asthma Prevalence and Control Among Adults --- United States, 2001. MMWR 2003;52(17):381-384
[2] U.S. Department of Health and Human Services, Healthy People 2010, Washington, D.C. //2004//

/2004/ CAI, First Five-funded through June 30, 2004, targets children with asthma birth to 5 years of age. There are two CMS CAI components: the Asthma Treatment Services (ATS) Project and the CHDP Asthma project. ATS provides outpatient visits, medications, medication administrative devices, and patient/parent education in three communities. Initial findings are that quality of life has improved and the number of hospitalizations, acute care visits, and ER visits related to asthma for enrolled children has decreased. In the CHDP Asthma Project, the CMS Branch provided training to over 5,200 pediatric providers in asthma management. This project has resulted in CHDP providers including asthma assessments in their periodic health assessments for 1.3 million CHDP children < 5. //2004//

#2
/2004/ Health Systems Capacity Indicator-HSCI- 2 (formerly Core Health Status Indicator CHSI #02A) is the percent of Medi-Cal enrolled children less one year who received at least one CHDP health assessment in the reporting year. In FY 2001-02 73.9 percent of Medi-Cal enrolled children under one year of age received care; an increase from 71.3 percent for FY 2000-01. This is probably an under-estimate since an increasing number of children are enrolled in MCMC plans, and there is under-reporting of data from these plans as the PM 160 is an "information only" form./2004//

/2004/ Current HSCI #2 activities include the continuation of Memoranda of Understanding between MCMC physicians and local CHDP programs. Each local CHDP program coordinates with plans to map out a procedure for working together. DHS staff provide technical assistance to local CHDP programs and MCMC plans to resolve problem areas. The CHDP program provides outreach to providers and children and their families (such as Health Fairs). The CMS Branch has been collaborating with the with the California Medical Home Project and the LA Medical Home Project. A policy is being drafted for a CCS Medical Home Pilot Project; LA County CCS is working with LA Care MCMC Plan for better coordination of care by the medical home. //2004//

#3
/2004/ Health Systems Capacity Indicator-HSCI- 3 (formerly Core Health Status Indicator

CHSI #02B) is the indicator for the percent of HF enrollees under one year of age who have received at least one CHDP health assessment. This data was not available for FY 2001-02. The HF plans do preventive examinations based on AAP guidelines. The HF program relies on the Health Plan Employer Data and Information Set (HEDIS) to determine the performance of the health plans. //2004//

#4
/2004/ Health Systems Capacity Indicator-HSCI-4 (formerly Core Health Status Indicator CHSI #3), is the percent of women (ages 15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index. For this indicator, there has been a small but continual rise, a 3.5 percent increase between 1997 and 2001. This is consistent with the increase in first trimester care. . However, California's 2001 rate of 76.6 percent of women with adequate prenatal care remains much lower than the national Healthy People 2010 goal of 90 percent. //2004//

#5
/2004/ Health Systems Capacity Indicator- HSCI-5 (formerly Core Health Status Indicator CHSI #6) compares Medicaid and Non-Medicaid. HSC 5a is the percent of low birth weight (<2,500 grams) by payment source indicated on the birth certificate. The percent of low birth weight births paid by Medi-Cal and all other payers was quite similar (Medicaid 6.5 percent and all others 6.2 percent). However, neither payment source reached the Healthy People 2010 target of 5.0 percent. Health System Capacity Indicator 5b compares the infant death rate between Medi-Cal and non-Medi-Cal births; the death rate among Medi-Cal births (6.3 per 1,000) was higher than non-Medi-Cal births (4.8 per 1,000) for 2000 (most current data available). Health System Capacity Indicator 5c shows first trimester prenatal care by payment source. The percent of births that entered prenatal care was 89.6 percent for non-Medi-Cal births, virtually achieving the Healthy People 2010 goal of 90 percent. However, rates for births paid by Medi-Cal were 79.2 percent, which is considerably less than non-Medi-Cal births. Health System Capacity Indicator 5d is the percent of women with adequate (observed to expected) prenatal visits greater or equal to 80 percent (Kotelchuck Index) prenatal care. This indicator is similar to HSC 4 except that Medi-Cal and non- Medi-Cal groups are presented separately. Thus, the 76.6 percent of all births is the same for both indicators. Non- Medi-Cal births are more likely than Medi-Cal births to have mothers receiving adequate prenatal care, 79.5 percent and 72.3 percent, respectively. However, both are much lower than the national Healthy People 2010 goal of 90 percent. //2004//

#6
/2004/ Health Systems Capacity Indicator- HSCI-6 (formerly Core Health Status Indicator CHSI #7). Health System Capacity Indicator 6a compares the percent of poverty for eligibility in the State's Medicaid and CHIP programs for infants (ages 0 to 1); Health System Capacity Indicator 6b compares the percent of poverty for eligibility in the State's Medicaid and CHIP programs for children ages 1 to 19; and Health System Capacity Indicator 6c compares the percent of poverty for eligibility in the State's Medicaid and CHIP programs for pregnant women. It is difficult to compare these measures to Medi-Cal and HF as the income eligibility criteria are different. Medi-Cal requires infants to be at or below 200 percent of the Federal Poverty Level; HF is more inclusive, using an eligibility level of at or below 250 percent. In Medi-Cal children in the age group 1 through 5 are required to be at 133 percent and 6 through 19 are required to be at 100 percent of the FPL to be eligible in 2001. The HF program is much more inclusive at 250 percent of FPL for children 1 through 19 for either 2000 or 2001. Medicaid requires pregnant women to be at or below 200 percent of the FPL in 2001. //2004//

#7

/2004/ Health Systems Capacity Indicator-HSCI- 7 (formerly DHSI #04) is the percent of EPSDT eligible children (CHDP in California) aged 6 through 9 years who received any dental services during the year. The goal of this indicator is to increase dental health services to Medi-Cal eligible children at an important stage of dental development. In FY 2001-02, 45.5 percent of eligible children received at least one dental referral during the year, an increase from 44.6 percent in FY 2000-01. The methodology for calculating this indicator changed in FY 2001-02. Applying this methodology to 1999-00 data yielded 43.8 percent of children receiving a dental referral. It is anticipated there will be larger increases in future years. //2004//

/2004/ The CHDP Gateway covers dental services for pre-enrolled children for up to two months and the opportunity to apply for permanent enrollment in Medi-Cal or HF. To improve the quality of dental screenings and facilitate more precise referrals to a dentist, the CHDP program has introduced the "PM 160 Dental Guide" to over 5200 CHDP providers. This tool visually depicts the four classifications of treatment needs for a dental referral as identified by the American Dental Association. Development of the "Orthodontic/Dental Handbook" to assist orthodontists and dentists to better understand the CCS program and accept more CCS children into their practices is another activity. The CMS Branch is working with the California Association of Orthodontists to encourage more orthodontic providers to become CCS-paneled. //2004/

#8
/2004/ Former FPM 1 is now Health Systems Capacity Indicator –HSCI-8. In the past, the numerator for this measure has been an estimate of the children who have received rehabilitation services, based on the number of children in the CCS program who had at least one rehabilitative service resulting in a claim paid by the Medi-Cal program. This method results in an over estimate of the numerator. The method used for FY 2002-03 is the number of children in the CMS Net system with eligibility aid codes of 20 or 60 (disabled children with SSI), most of whom will be receiving MTP services. The number from CMS Net is then extrapolated to all counties. This percentage will improve when all counties are on CMS Net. Also, CCS will have the capability in the future to retrieve data for particular age groups. Current data are for all children under 21 years of age. //2004//

/2004/ The denominator used in the past for HSCI #8 was the unduplicated count of Medi-Cal enrolled children age 15 and under with aid codes 20 and 60. For FY 2002-03, the denominator is from the Social Security Administration Office of Policy, Children Receiving SSI for December 2002 (for children under 16 years). With these changes, the performance indicator is 23.0 percent, lower than in the past, but a closer estimate of the percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State CSHCN Program. Since the numerator and denominator were derived differently for FY 2002, a comparison will need to be made with future years. However, the applicability of this performance measure for California is again questioned. Many children receiving SSI with mental health and developmental disabilities or delays are not medically eligible for CCS but are eligible for other state-funded services such as regional center services.//2004//

#9
/2004/ Health Systems Capacity Indicator- HSCI-9 (HSCI #9a was formerly Core Health Status Indicator CHSI #8a). HSCI 9a; general MCH data capacity. The MCH Branch has maintained linked files of all infant birth and death certificates for deliveries in California since 1995. Data has been used for a variety of research endeavors including the assessment of infant mortality rates across the state with future plans to potentially look at SIDS data, as well as expanding longitudinally what is known regarding other MCH indicators. //2004//

/2004/ DHS has the capacity to link birth certificate files with Medicaid files but has found annually linked birth certificate-hospital discharge files to be a more useful tool for MCH surveillance and early identification of infants and children with special health care needs in California. Hospital discharge data has at least 90% of in-State hospital discharges and, unlike Medicaid data, hospital discharge files are population-based. Thus, tracking of maternal morbidity and mortality using hospital discharge data are unaffected by client Medicaid eligibility. This data has provided valuable hospitalization information for cause of death data among pregnant women. Birth certificate data and WIC eligibility files were linked in 1999 but because of budgetary constraints have not been done in the past two years. This linkage remains a goal to accomplish in future years, particularly since the MCH Branch continues to have direct access to the WIC electronic databases for analysis. Although the MCH Branch does not have the ability to link birth certificate and newborn screening files, there have been recent discussions on linking newborn screening data obtained through the Genetic Disease Branch with electronic data sets on prenatal care services. //2004//

/2004/ An important source of data for monitoring the health of California's mothers and children is the Maternal and Infant Health Assessment (MIHA) survey, an annual, ongoing survey of women who delivered a live-born infant in California. The survey is modeled after CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) and is self-administered 10-14 weeks after birth to approximately 4000 women. The data are generalizable to all mothers who were California residents and delivered a live-born infant in the year of interest. //2004//

/2004/ HSCI 9b; data capacity for adolescent tobacco use. Developed by CDC in 1990, the Youth Risk Behavior Survey (YRBS) was established to monitor priority health risks including tobacco use. Conducted every two years, the YRBS includes national, state, and local school-based surveys of representative samples of 9th through 12th grade students. 1999 was the last year the YRBS was administered in California. The California Healthy Kids Survey (CHKS), administered by the CDE, replaced the YRBS. To date over 600 school districts in California have administered the CHKS to their students. The CHKS can be used to assess data on alcohol use, tobacco, and other drugs. As the largest state survey conducted in the United States, the California Health Interview Survey (CHIS) provides both statewide and local-level information for most counties for purposes of local planning and for making comparisons between counties and regions. //2004//

/2004/ HSCI 9c; data capacity for obesity/overweight. YRBS includes data on height and weight pertaining to California. Likewise the CHKS contains questions drawn primarily from the national YRBS, including questions pertaining to obesity among children. The PedNSS, likewise administered through CDC, provides a valuable framework for tabulating and interpreting state-specific information on the nutritional characteristics of low-income children. California submits data from all CHDP health assessments to PedNSS.//2004//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Government Performance and Results Act (GPRA – Public Law 103-62) requires that each Federal agency establish performance measures that can be reported as part of the budgetary process that links funding decisions with performance and related outcome measures to see if there were improved outcomes for target populations.

Since 1999 MCHB has included performance plans and performance information in its

budget submission. MCHB must submit annual reports to Congress on the actual performance achieved compared to that proposed in the performance plan. This section of the guidance describes how the Federal-State partnership will implement these performance-reporting requirements.

Based on input from each of the 61 MCH jurisdictions (58 counties and 3 cities), the State of California prepared a Five Year Needs Assessment in 2000. From this Needs Assessment, the State developed a set of priority needs over the next five years. Nine State Performance Measures were developed to reflect the priority needs:

State Performance Measure 1: The percent of children whose family income is less than 200 percent of the Federal Poverty Level who received at least one preventive medical exam during the fiscal year.
State Performance Measure 2: The percent of low-income children who are above the 95th percentile of weight-for-height, or overweight.
State Performance Measure 3: The rate of deaths per 100,000 children aged 1 through 4 years caused by drowning in swimming pools.
State Performance Measure 4 : the rate of deaths per 100,000 adolescents aged 15 through 19 years caused by homicide.
State Performance Measure 5: The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.
State Performance Measure 6: The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System.
State Performance Measure 7: The percent of California Children Services (CCS) enrolled children registered in CMS Net, the statewide automated case management and data collection system for CCS.
State Performance Measure 8: The percent of women 18 years or older reporting intimate partner physical abuse in the past 12 months.
State Performance Measure 9: The percent of youth aged 12-17 years who report smoking cigarettes in the past 30 days.

California’s progress on the 27 Performance Measures is related to California’s priority needs; 18 are Federally mandated and 9 are selected by the State. The Performance Measures correspond to the four levels of the pyramid: direct health care services, enabling services, population-based services, and infrastructure building services. For a discussion of specific programs associated with each Performance Measure, please refer to Sections C National Performance Measures and D State Performance Measures.

B. State Priorities

Please refer to Attachments for further information on the development of the Annual Objectives for the National Performance Measures and the selection of State Performance Measures.

The five-year needs assessment led to the identification of the priorities identified below for the population of pregnant women, mothers, infants, children, and CSHCN for the period of FFY 2001-2005. The priority needs encompass all levels of the health services pyramid and in some cases span pyramid levels.

The main priority need identified that relates to direct health care services is the need to maintain and improve the State health care programs for children particularly CSHCN. The two primary programs serving children, CHDP and CCS, are the core "safety net" for children's health care in the state. Performance Measures associated with Direct Services include: NPM 1, NPM 2, and SPM 1.

A number of priority needs were identified that relate to enabling services. The major needs in this area concern: racial and ethnic disparities in infant health and mortality; existing disparities in the proportion of low birthweight; issues of access to maternal health care; issues of access to health care for children and CSHCN; and the presence of community, family and domestic violence. Performance Measures associated with Enabling Services include: NPM 3 and SPM 8.

Priority needs relating to population-based services are: the need to reduce the large number of adolescents giving birth; need to increase the low breast-feeding rates; and need to reduce the high intentional and non-intentional injury rates. Other population-based concerns are: the need for promotion of healthy lifestyle practices for children and adolescents and the need for outreach through health programs to aid catchment of CSHCN. Performance Measures associated with Population-based Services include: NPM 4, NPM 5, NPM 6, NPM 7, NPM 8, NPM 9, NPM 10, SPM 2, SPM 3, SPM 4, SPM 5, SPM 6, and SPM 9.

An identified priority need for infrastructure building relates to the quality of maternal health care. Many of the ethnic disparities in infant health care and proportion of low birthweight infants also relate to infrastructure issues. Infrastructure building is pertinent to State priority needs for children with respect to: the quality of primary and specialty care providers for children and CSHCN; better coordination of services for CSHCN; and the need to expand the capabilities of the statewide case management and data collection system for CSHCN (CMS Net). Performance Measures associated with Infrastructure Services include: NPM 11, NPM 12, NPM 13, NPM 14, NPM 15, NPM 16, NPM 17, NPM 18, and SPM 7.

California has identified the following priorities for Title V activities for FFY 2000-2005.

California Title V Priorities:

-Eliminate racial and ethnic disparities in infant health, including gaps in the infant mortality rate and the proportion of low and very low birthweight live-born infants.

-Promote safe motherhood by improving early access to and the quality of maternal health care for all women.

-Improve access to quality primary and specialty care providers, including dental, for all children, particularly Children with Special Health Care Needs.

-Reduce the adolescent birth rate.

-Increase breastfeeding rates among newborns.

-Promote healthy lifestyle practices among children and adolescents with emphasis on smoking prevention, adequate nutrition, regular physical activity, and oral health.

-Decrease intentional and unintentional injury death rates among children and adolescents.

-Reduce the prevalence of community, family, and domestic violence.

-Improve coordination and outreach with other health programs to facilitate delivery of health care services to Children with Special Health Care Needs.

-Continue to expand the CCS statewide automated case management and data collection system, CMS Net, to improve tracking and monitoring services and outcomes for CSHCN.

California's progress on the 27 Performance Measures are related to California's priority needs; 18 are Federally mandated and 9 are selected by the State. The data presented are associated with the four levels of the pyramid: direct health care services, enabling services, population-based services, and infrastructure building services. The data are also related to population groups: pregnant women, mothers and infants, children, adolescents, and CSHCN. For a discussion of specific programs associated with each Performance Measure, please refer to Sections C National Performance Measures and D State Performance Measures. The Performance Measures are also listed on Figures 4a and 4b (Performance Measures Summary Sheet). The reporting year for FFY 2004 is 2002. The data source for many of the National and State Measures is from FFY 2001; however, the same 2001 indicators are used to estimate data for FFY 2002.

View Attachment

C. National Performance Measures

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State*

a. Last Year's Accomplishments

Federal Performance Measure 4, now National Performance Measure 1, newborn screening for genetic metabolic and hematologic disorders, has been in effect in California for many years. In 1998, 98.8 percent of newborns were screened, a figure very close to the 1998 (99.0 percent) federal objective. Given the near universal newborn genetic screening coverage for California, significant changes in this measure are not expected over time.
/2002/ Federal Performance Measure 4, indicates that 98.8 percent of newborns received at least one genetic screening test in 1999. The figure remained constant from 1998 and has been close to 99 percent for several years. Since such a high coverage level has been achieved and maintained, no change is predicted over the reporting period.
/2003/ In 2000, 99.0 percent of newborns received at least one genetic screening for each of the specified conditions, Federal Performance Measure 4. With near universal coverage of these newborn screening tests, the objective of maintaining the existing coverage level is being achieved.

The Genetic Disease Branch (GDB) conducts two large screening programs for the prevention and detection of neonatal and prenatal disorders. Services include testing and counseling for patients as well as public information and professional education. Genetic screening is a statutorily mandated service available to all women and infants and their families. In 1998 and 1999, the testing panel for newborns included primary screening for phenylketonuria (PKU), hypothyroidism, galactosemia, and hemoglobinopathy. The program followed the infant until a confirmatory diagnosis was received and the infant's treatment was established with a health care provider. The expanded alpha fetoprotein program is another prenatal screening program for the detection of neural tube defects (spina bifida, anencephaly, encephalocele), abdominal wall defects, trisomy 21, 18, 13, and other chromosomal abnormalities. Women with positive screening tests are referred to prenatal diagnostic centers under contract with GDB.

/2003/ Governor Davis signed into law AB 2427, which provides for updating and expanding California's newborn screening program, including development and evaluation of expanded genetic disease testing utilizing Tandem Mass Spectrometry (MS/MS). The GDB is currently conducting a study to determine which of the disorders identifiable through MS/MS meet the criteria for inclusion in California's mandatory Newborn Screening Program. The CMS Branch is working with GDB to ensure that infants with potentially abnormal results from MS/MS testing receive diagnostic evaluations at one of the CCS approved Metabolic SCCs in the state. The county CCS programs are expediting these referrals to facilitate a rapid turnaround time for diagnosing a metabolic illness.

b. Current Activities

/2004/ Using the old definition, the percent of newborns receiving genetic screening for conditions mandated by the State Newborn Screening (NBS) program increased to 99.9 percent. However, the definition of FPM #4, now National Performance Measure 1, changed this year to the percent of infants with positive screens who received "appropriate follow-up as defined by their State." In 2001, of the overall confirmed cases of the abnormalities for which screening tests were performed through the NBS program, 98.4 percent (375/381) received appropriate follow-up treatment (phenylketonuria 100 percent [16/16], congenital hypothyroidism 100 percent [261/261], galactosemia 100 percent [4/4], and sickle cell disease 94 percent [94/100]). The main reason that follow-up may not reach 100 percent is the inability to track all affected children who relocate. //2004//

/2004/ The nearly universal screening and follow-up cannot be expected to increase significantly. The percent of newborns screened continues to effectively meet or exceed the annual objectives (99.0 percent was the objective for 2001). No annual objective was provided for the percent receiving follow-up treatment. GDB is evaluating its recently completed pilot project to assess the feasibility of using MS/MS to screen for additional metabolic disorders. //2004//

/2004/ Current activities include: 1) Purchase of phenylketonuria formula and food products for individuals. 2) Contracts providing statewide coverage for consultation for related metabolic conditions. 3) Development of a data system linking newborn screening records with birth certificates. 4) Arranging transportation, as needed, to access follow up services. //2004//

c. Plan for the Coming Year

/2004/ Funding for the MS/MS pilot project ended June 30, 2003. As of May 2, 2003, 309,074 newborns were screened and 41 have been diagnosed with metabolic disorders. Approximately 100 suspicious screening results are still being evaluated. //2004//

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

a. Last Year's Accomplishments

Federal Performance Measure 2 has been dropped. National Performance

Measure 2 is a brand new measure; discussion of past years accomplishments is not required by HRSA.

b. Current Activities

/2004/ NPM #2 is the percent of CSHCN age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive. This is one of five measures (see also NPM 3,4,5, and 6) from the National Survey of CSHCN The survey,designed to assess the prevalence, characteristics, and health care needs of noninstitutionalized CSHCN,was conducted from October 2000 to April 2002. The survey explored the extent to which CSHCN have medical homes, adequate health insurance, and access to needed services. For the survey results, each of the five core outcomes was disaggregated into its essential elements or underlying concepts, and these essential elements or underlying concepts were then translated into measurable criteria using items contained in the survey. Datasets were re-weighted when the recently released Census 2000 counts became available. Based on this survey, 47.6 percent of California's CCS clients age 0 to 18 have families partnering in decision- making at all levels and are satisfied with the services they receive. Since this is a new performance measure, no comparisons to previous years are possible this year. Current activities include: 1) CISS grant Family Centered Survey data analysis. 2) Development of CCS program policy letter for Family-Centered Care (FCC) for county CCS programs. 3) Development of FCC Training Guide for county CCS programs. 4) Counties implementing new CCS Staffing Standards for inclusion of a parent liaison. //2004//

c. Plan for the Coming Year

/2004/ Provision of family-centered care is extremely important to the CMS Branch. The partnership with the University of Southern California (USC), University Affiliated Programs (UAP) to administer the CISS Project continues. The Project is promoting the adoption of family-centered policies and services within the CCS program. A family-centered training guide for county CCS programs is under development, new CCS Staffing Standards include a parent liaison in county staffing plans. The CISS grant Family Centered Survey data analysis will continue.//2004//

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

a. Last Year's Accomplishments

/2003/ From 1999 to 2000, FPM #3, now NPM #3, has increased from 23.8 percent to 33.4 percent. This increase reflects better accuracy of information added to the system regarding individual children's medical providers; however, it is still an underestimate as CCS case managers either do not have this information or do not document the provider's name. The registration component of CMS Net includes a specific field for the medical home, and the addition of this entry space, together with teaching regarding the importance of this entry information, should result in more accurate data collection over the next few years. In reviewing this performance measure since 1997, CMS can identify no plausible explanation for

the increase to 63 percent reported in FY 1998. There may have been a data extraction error in 1998.

b. Current Activities

/2004/ NPM #3 has been changed to measure the percent of CSHCN age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. The National CSHCN Survey indicates 44.7 percent of California's CCS clients receive coordinated, ongoing, comprehensive care within a medical home. The CMS Branch is also able to retrieve data for the medical home from CMS Net; 42 percent of CCS clients have medical homes based on CMS Net, so the results are similar for these two methodologies of determining the percentage of CSHCN with medical homes. A review of the CMS Net data reveals that 35 percent of counties are reporting that over 60 percent of their CSHCN have a medical home. As large counties become part of the CMS Net system and as staff learn the importance of recording the medical home, the data will become more accurate. Since this is the first year for the National Survey results, trends and comparisons will need to wait for the coming years. The CMS Branch is collaborating with the California Medical Home Project and with the Los Angeles (LA) Medical Home Project. A policy is being drafted for a CCS Medical Home Pilot Project. LA County CCS is working with LA Care Medi-Cal Managed Care Plan for better coordination of care by the medical home. //2004//

c. Plan for the Coming Year

/2004/Current activities and plans for the coming year include: 1) Collaboration with California Medical Home Project – Improving Care Delivery for CSHCN – sponsored by California Healthcare Foundation with children in CCS program as target population. 2) CMS State and county staff involvement in the LA Medical Home Project with web site and Medical Home Assessment Survey for Physicians as two of many activities. 3) LA Care and Health Net MCMC Plans partnering with LA County CCS in developing and implementing a plan to eliminate the barrier for primary care physicians' knowledge of their patients' participation in the CCS program. 4) Information sharing between LA CCS Automated Case Management System and LA Care Medi-Cal Managed Care Plan for better coordination of care by the medical home.//2004//

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

a. Last Year's Accomplishments

FPM #11 is now NPM #4.
/2003/ The percent of CCS eligible children with a source of insurance, Federal Performance Measure 11, was 97 percent for FY 2000-01. Seventy-five percent of children had Medi-Cal coverage, 7.5 percent had HF coverage, and 14.5 percent had private/other insurance.

b. Current Activities

/2004/ NPM #4, has changed from the former FPM 11. NPM #4 is from the National

CSHCN Survey. For the survey period from October 2000 to April 2002, 59.3 percent of families of CSHCN age 0 to 18 years in California had adequate private and/or public insurance to pay for the services they needed. Both in FY2000-01 and 2001-02, the CMS Branch estimated that 97 percent of CCS eligible children have third party coverage. The survey introduces the words, "adequate… to pay for services" to the new measure. This is self-reported by the household and may not be accurate as many people, including those with private insurance, are concerned that their coverage may not be adequate, particularly if they were to become severely ill. CMS Branch activities to increase health coverage for children include development and implementation of the CHDP Gateway and continuation of the CAI's ATS Project. //2004//

/2004/ Implementation of the CHDP Gateway is a major current activity. Approximately 1.1 million children receiving CHDP services are not enrolled in HF or Medi-Cal. The benefit package for non-Medi-Cal eligible clients under the CHDP program is limited to physical assessments, laboratory testing, and immunizations. It is estimated that approximately 760,000 children receiving state-funded CHDP services are eligible for comprehensive coverage through HF or Medi-Cal. Using the CHDP program as a gateway to HF and Medi-Cal will enable these children to receive full health care coverage. //2004//

c. Plan for the Coming Year

/2004/ Current activities and plans for the coming year include: 1) Implementation of the CHDP Gateway to enroll eligible children in Medi-Cal or Healthy Families. 2) Trainings around the state and video teleconference trainings on the Gateway for state and county CMS staff and CHDP providers. 3) Continuation of the CAI that enrolls uninsured children under five years of age into the ATS Project. /2004//

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

a. Last Year's Accomplishments

National Performance Measure #5 is a new measure.

b. Current Activities

/2004/ National Performance Measure 5, based on the results of a National CSHCN Survey measure, is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily. For California, 65.9 percent of CCS eligible children and their families reported that services were easily accessed. The CMS Branch has a number of major activities to improve family-centered care services including developing policy to instruct counties on methods to collaborate with families and community organizations in the provision of services, and assisting CCS approved hospitals and SCCs with the implementation of family-centered care. The CMS Branch continues collaboration with Family Voices, and with parent representatives and diverse parent groups through the Interagency Coordinating Council for Early Start. In addition, the CCS

program has continued to facilitate family-centered care and services for CSHCN and their families when needed through reimbursing lodging, meals, and travel for SCC visits and hospitalizations; CCS county programs have helped families make appointments and assisted with clustering appointments on the same day or over two days and then assisted with lodging, meals and travel. //2004//

c. Plan for the Coming Year

/2004/ Current activities and plans for the coming year include: 1)development of CCS program policy letter for family-centered care instructing counties to collaborate with families and community organizations in the provision of services; 2) counties' implementation of CCS instructions to meet with mental health administrators to make outpatient mental health services more accessible to CSHCN; 3) state CCS staff reviewing CCS-approved hospitals, NICUs, PICUs, and SCCs and those newly applying for implementation of family-centered care; 4) development of family-centered care training guide for county CCS programs; 5) support for local CCS program innovative projects to coordinate services; 6) revision and issuance of the DDS Interagency Agreement; 7) Issuance of the Early Start, CCS Interagency Agreement; 8) participation on an interagency committee addressing collaboration on the foster care system redesign. //2004//

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

a. Last Year's Accomplishments

National Performance Measure #6 is a new measure.

b. Current Activities

/2004/ National Performance Measure 6, also a new measure based on the National CSHCN Survey, is the percentage of youth who received the services necessary to make transitions to all aspects of adult life. Due to small sample sizes, the relative standard error for every state except Maine was greater than 30 percent, so the national average is reported which is 5.8 percent. This result is extremely low, but since this is the first year for this measure, trends and comparisons will have to wait for the coming years. Some county CCS programs have been aggressively tackling transitional services for CCS eligible children, but most counties need to develop and implement plans of action. Within the past year, there has been a training on transition services for the San Francisco Bay Area counties that included representatives from hospitals and community agencies such as Support for Families. The Alameda County CCS program has a very active transition planning process that was presented at the training. There have also been transition-planning activities in southern California. Seven county CCS Programs are ensuring at a minimum that all identified needs, supplies, surgeries, and insurance eligibility are addressed before the age of 21. Staff from the MTP in Ventura County regularly attend and participate with the Special Education Local Planning Areas (SELPA) Interagency Coordinating Transition Council and there is coordinated SELPA training on the process of transitioning to adulthood. In Kern County, the emphasis of the MTP Physiatry Clinic is referral for transitioning services for older children who have sustained spinal cord injuries, traumatic brain injuries, vascular accidents

and related disabilities. In Santa Barbara County, there is a Transition Committee of CCS staff that receives input from CCS parents, young adult clients, and the Family Support Center to assess and develop ways to infuse the concept of transition into all CCS services and functions. The committee organizes in-service training and presentations for CCS staff. Current and former CCS clients attend meetings to share their experiences. //2004//

c. Plan for the Coming Year

/2004/ Current activities and plans for the coming year include: 1) the CMS Branch is developing a workgroup of state staff, county representatives, community-based organization leaders, and a parent liaison to develop policy and policy implementation guidelines for transition planning; 2) state CCS staff are assessing transition planning for their clients beginning at age 14 years during the reviews of established CCS-approved hospitals, PICUs, and SCCs and those newly applying for approval; 3) trainings on transition services are continuing; 4) county CCS programs will continue or initiate transition service planning. //2004//

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

a. Last Year's Accomplishments

National Performance Measure 7, formerly, Federal Performance Measure 5, measures the percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B. According to the National Immunization Survey (NIS) data from FY 97-98, 75.9 percent of California, children in aged 19-35 months, had completed the 4:3:1:3 series as identified in Federal Performance Measure 5. This series consists of four or more doses of diphtheria and tetanus toxoids and pertussis vaccine/diphtheria and tetanus toxoid (DPT/DT); three or more doses of poliovirus vaccine; one or more doses of measles-containing vaccine (MCV); and three or more doses of Haemophilus influenza type b vaccine (Hib). The percent coverage for 1997/98, 75.9 percent, fell just below the 1998 objective of 76.0 percent and has shown no statistically significant change over the time period 1995-98, when the 4:3:1:3 has been monitored. Efforts are currently underway to increase immunization rates through raising provider and public awareness. CMS, Medi-Cal, the Immunization Branch and managed care plans are collaborating on an immunization improvement project that is related to Federal Government Performance and Results Act (GPRA) reporting on immunization.

/2002/ FPM 5 was 75.3 in 1999. The 1999 objective of 77 percent was not achieved. Increasing access to preventive services through the HFP and Medi-Cal enrollment should contribute to increasing immunization coverage in the next five years. To promote childhood immunization, the CHDP program assures access to vaccines that are required for school entry and has issued provider information notices that contain updated information on the vaccines that are benefits of the CHDP program. CHDP also maintains access to vaccines that are indicated in some children, reimbursing medical providers for vaccine purchase when these vaccines are not supplied by the Federal Vaccines for Children program.

/2003/ Federal Performance Measure 5 was 75.3 percent in 2000, indicating no

change since 1999. The 2000 objective was not achieved. While California has not expanded series complete immunization coverage since 1998, it appears to be performing well compared with other large states. The three urban areas included in the California Immunization Action Plan, Los Angeles, Santa Clara, and San Diego, performed very well in comparison with other urban areas included in the NIS(39). The CHDP program provided 4,367,150 individual immunizations in FY 1999-2000. This represents a 2.4 percent increase over FY 1998-1999. With more children enrolling in Healthy Families or Medi-Cal through the CHDP Gateway and having access to primary and preventive care, an increase in expected in the number of children receiving immunizations.

b. Current Activities

/2004/ Although 419,944 children (74.9 percent) through age 2 received immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B, in 2001 California still remains below the annual performance objective of 76.4 percent. The percentage of immunizations have remained steady since 1996 at or above 74 percent. Continued efforts through Healthy Start, the Health Insurance Plan of California (HIPC) and AIM have helped substantially in providing adequate health care access for kids. HF has been valuable in increasing the number of children receiving immunizations. //2004//

/2004/ With annual appropriations since 1995 of $3.5 million, California will move to focusing on the improvement of regional registries and the creation of a state hub capable of linking all regions while unifying the statewide system for identifying pockets of need and developing adequate interventions. As of 2001, nine regions have been established, covering 40 California counties and reaching nearly 85 percent of the state's population. Private provider participation will be necessary for the electronic exchange of information on patients moving between regions and jurisdictions while allowing schools, childcare centers, Medi-Cal, WIC, and Cal-WORKS to link into regional registries. //2004//

c. Plan for the Coming Year

/2004/ In the future MCH and CMS will continue advocating for families to join Medi-Cal or HF. With more children having access to primary and preventive care, the number of children receiving immunizations is expected to increase. //2004//

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

a. Last Year's Accomplishments

Federal Performance Measure 6, now National Performance Measure 8, decreasing the birth rate among adolescents, is one of California's highest health priorities. Between 1987 and 1994, the birth rate among 15-17 year olds increased from 34 to 45 births per 1,000 women. By 1998, this rate for the same age group had fallen to 32.6 per 1,000 women, meeting the target of 35.6 births. Past and projected declines in the teen birth rate reflect the extensive State leadership and investment in teen pregnancy prevention activities such as the Community Challenge Grants, Partnership for Responsible Parenting campaign, Adolescent Sibling Pregnancy Prevention Program (ASPPP), TeenSMART, Male Involvement

Program, Information and Education program, and expanded access to comprehensive family planning services (Family PACT). Further decreases in teen birth rates are projected based on the continued State involvement in prevention activities.

/2002/ Federal Performance Measure 6, the rate of births to teenagers aged 15 through 17 years in California continued to decline in 1999, falling from 32.6 births per 1,000 teens to 30.1. The Department of Health Services will continue to address teen pregnancy prevention through the Maternal and Child Health Branch's Adolescent Family Life Program and a variety of programs in the Office of Family Planning (OFP). Heightened attention to the role of adolescent males in pregnancy prevention has been promoted through the Male Involvement Program of OFP. In addition, an increasing focus on expanding opportunities for California's adolescents can also contribute to preventing teen births. A continuing decline in the adolescent birth rate among 15 through 17 year olds is projected through 2006.

/2003/ Federal Performance Measure 6, continued its decade-long decline in 2000; the rate fell from 30.1 in 1999 to 27.2 in 2000. The 2000 objective, a rate of 28.7 births per 1,000 was achieved. Programs of the Office of Family Planning (OFP) that expand access to family planning services and increase male involvement in the planning process and the prevention of unwanted pregnancies have made significant contributions to this success. OFP programs include the Community Challenge Grant (CCG) program that funds approximately 134 community agencies and serves approximately 120,000 teens annually; the Male Involvement Program (MIP) with funding to 25 agencies and serving roughly 31,000 adolescent boys and young adult males annually; Information and Education (I&E) projects operating in 30 community agencies and serving approximately 75,000 youth in grades 6 through 12 annually, and the TeenSMART Outreach program that offers in-depth counseling related to sexual and contraceptive concerns of adolescents who access family planning services through OFP's Family PACT program.

b. Current Activities

/2004/ National Performance Measure 8 (formerly Federal Performance Measure 6), declined from 27.2 to 24.4 births per 1,000 females aged 15 through 17 years between 2000 and 2001. Although disparities still exist, a decrease in teen birth rates was observed among all racial/ethnic groups. Although California met and exceeded the annual objective of 25.0 births per 1,000 females 15-17 years old, teenage pregnancy prevention efforts must continue in order to maintain and further reduce this rate. //2004//

/2004/ The current Administration has a made a strong commitment to "reducing the number of children having children." This commitment was evidenced by Governor Gray Davis' proclamation of May 2003 as "Teenage Pregnancy Prevention Month". DHS continues to support teenage pregnancy prevention efforts through programs within the MCH and the OFP. MCH's AFLP and ASPPP provide case management services to pregnant and/or parenting teenagers and their siblings. The OFP supports clinical family planning services through the Family PACT. In addition, community based educational services are provided through Information and Education Program (I & E) projects operating in 30 community agencies and served approximately 75,000 youth in grades 6 through 12; Male Involvement Program that funds 28 agencies and served about 29,000 adolescent boys and young adult males; and the Community Challenge Grant Program which funds approximately 130 community agencies and served approximately 200,000 teens this year. To

further support teenage pregnancy prevention efforts, DHS launched the "It's Up to Me" pregnancy prevention media campaign in 2000. "It's Up to Me" addresses teen pregnancy by involving teens, promoting responsible fatherhood, increasing awareness of Family PACT, and encouraging communication between adults and teens.//2004//

/2004/ In addition to the DHS teen pregnancy prevention services, DSS operates the Cal Learn program and CDE funds 140 school districts and county offices of education throughout the State to operate the California School Age Families Education (Cal-SAFE) program. Cal-SAFE operates collaboratively with both AFLP and the Cal Learn program. //2004//

c. Plan for the Coming Year

/2004/ Teen pregnancy will continue to be a major issue for California in spite of the considerable success in the reduction of teen birth rates over the past ten years, given the changing demographics of California's youth population and the State projections that the recent teen birthrate declines will soon reverse and begin to accelerate rapidly. These projections are primarily based on the growth of the Hispanic teen population relative to other group as the Hispanic teen birth rate is substantially higher than the overall state rate. By 2008, the annual number of teen births in California is projected to exceed 66,000—a projected 23 percent increase from 2001 teen births. //2004//

/2004/ In the current fiscal environment, the "It's Up to Me" media campaign is expected to be eliminated; programs addressing teen pregnancy are expected to face reductions. Funding for the Cal Learn program contract between DHS and DSS will not be available in FY 2003-2004. Funding for the Cal Learn program contract between DHS and DSS will not be available in FY 2003-04. Funding for the Cal-SAFE program operation budget is proposed to be included in a categorical block grant. //2004//

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

a. Last Year's Accomplishments

National Performance Measure 9, formerly Federal Performance Measure 7, children's access to preventive dental services is assessed in relation to the percent of third grade children who have received protective sealants on at least one permanent molar tooth, Federal Performance Measure 7. In 1998, 17.6 percent of third graders had a protective sealant. The 1998 objective (10.6 percent) was achieved. Comparable data on sealants is unavailable for the period 1996-98 because of a change in the methodology of analysis. Further expansion of HF and Medi-Cal enrollment, which provide coverage of dental services, is expected to contribute to increased access to preventive dental services in the period from 2001-2005.

/2002/ FPM 7 increased from 17.6 to 18.7 percent from 1998 to 1999. The 1999 annual objective of 18.6 percent was achieved. The appointment of the Associate Director for Public Health Programs to direct the development of statewide oral health policy and evaluate the operation and effectiveness of California's oral health

programs is expected to strengthen California's oral health activities through expanded coordination and collaboration. Expanded oral health activities in local MCH programs are also expected to contribute to continuing improvement.

/2003/ FPM 7 remained at 18.7 percent in 2000, falling short of the annual objective of 19.6 percent, and showing no increase from 1999. The reasons for this lack of progress are not known but the limited access to dentists who will accept children with Medi-Cal may be contributing to the problem.

Several counties have allocated funds from their local CCCF (Proposition 10) for services related to oral health. In addition, the State CCCF has listed oral health as one of its five priorities. These initiatives are indicative of the State's commitment to combating dental illness in the MCH population through prevention and improved access to care. In addition, the CCLDMCAH included oral health as one of its priorities. The local directors will address oral health needs in their strategic planning and by creating an oral health workgroup. In addition, to meet the growing demand for technical assistance, at both the state and local levels, the MCH Branch has contracted with UCSF for a licensed dentist to serve as the MCH Oral Health Policy Consultant at 0.5 FTE. This consultant has the responsibility to continue to convene the DHS Dental Workgroup that was created five years ago to bring together all oral health staff at the state level to foster collaboration and partnerships in oral health. In addition to the state oral health staff, this group includes representatives of key private organizations such as the California Dental Association, the Dental Health Foundation, and the CCCF.

b. Current Activities

/2004/ In 2001, 19.5 percent of third grade children had protective sealants on at least one permanent molar tooth, a four percent increase from 18.7 percent in 2000 and better than the 2001 objective of 18.7 percent. However, this falls far short of the Healthy People 2010 objective of 50 percent for 8-year-old children. //2004//

/2004/ An oral health consultant was hired to provide technical assistance to the state MCH Branch, including tracking the percentage of third grade children with protective sealants on at least one permanent molar. However, the MCH Branch has not had funds to collect surveillance data on sealant prevalence. In addition, WIC and MCH Branches jointly purchased toothbrushes and toothpaste that were distributed to participants in local WIC and MCH programs as education and incentive tools. The Nutrition Network funded the development of a brochure and a poster to inform providers about oral health and nutrition. //2004//

/2004/ A significant improvement in oral health is the slow but steady progress in community water fluoridation in the last five years. In 1998, only 17 percent of Californians had access to fluoridated drinking water. Following the passage of AB 733 in 1995, the cities of Los Angeles and Sacramento were fluoridated in 1999 and 2000. In addition, there was voluntary fluoridation in Mountain View, Pico Rivera, Yuba City, and Port Hueneme. The Helix Water District in San Diego County, the city of Escondido, the San Francisco Public Utility Commission and Daly City have all begun the process of constructing fluoridation systems and are prepared to fluoridate within the next two years. The City of Watsonville is under State orders to comply with the law. Today, almost 30 percent of Californians have access to fluoridated drinking water. Finally, the Metropolitan Water District of Southern California recently voted to fluoridate their five treatment plants, which will add an additional 18 million people (but not all optimally fluoridated) to the numbers

noted above, and will move California to approximately 60 percent of residents having fluoridated water. //2004//

c. Plan for the Coming Year

/2004/ Many counties continue to promote oral health and fluoridation programs, but the State will only be able to address National Performance Measure 9 when appropriate funds become allocated for sealant promotion, placement, and continuous surveillance of prevalence.//2004//

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

a. Last Year's Accomplishments

The number of youth who die or suffer disabilities caused by intentional and unintentional injuries is a major public health problem. Unintentional injuries are the leading cause of death among children 1-14 years of age. Three State Performance Measures examine sentinel injuries. These are: pool drowning among 1-4 year olds, State Performance Measure 3; homicides among 15 through 19 year olds, State Performance Measure 4; and motor vehicle deaths among 15 through 19 year olds, State Performance Measure 5. Efforts to prevent injuries include collaboration with several State agencies addressing injury mortality and morbidity, and participation in and sponsorship of the annual statewide injury conference.

Motor vehicle accidents are the leading cause of death among children 0-14 years of age. A review of the motor vehicle death rates in this age group from 1990-1998 suggests a statistically significant downward trend. National Performance Measure 10, formerly, Federal Performance Measure 8, examines motor vehicle deaths among 0 through 14 year olds. In 1990, there were 5.4 deaths per 100,000 0-14 year olds compared with 2.8 in 1998. The 1998 annual objective of 2.9 deaths per 100,000 was met. Increased enforcement of drinking and driving laws and passenger restraint laws, along with public education campaigns addressing the risks of drinking while driving as well as road safety improvements have contributed to this notable progress.

/2002/ FPM 8 was 2.9 in 1999, compared with 2.8 in 1998. The 1999 annual objective of 2.6 was not achieved. Caution should be applied in comparing 1999 mortality-related measures to rates prior to that year because of the uncertainty regarding the comparability of data resulting from the shift from the codes used through 1998 to the ICD10 codes used in 1999. Through the continuing integration of childhood injury prevention activities in local MCH programs, the MCH Branch expects to achieve further gradual reductions in the rate over the next five years. The MCH Branch increased its support of local Childhood Injury Prevention Programs (CIPP) from three over the past three years (at an annual cost of $90,000) to five local jurisdictions at a total annual cost of over $200,000.

/2003/ At 2.7 deaths (per 100,000) in 2000, Federal Performance Measure 8, fell from 2.9 in 1999. The annual objective was met. The local health departments continue to work with the California Center for Childhood Injury Prevention on the development and implementation of local projects.

To reduce childhood injury-related mortality and morbidity, the Childhood Injury Prevention Program contracted with the CIPPP at SDSU. CIPPP provided technical assistance to local and statewide organizations, including local MCAH programs. CIPPP also worked with five local MCAH jurisdictions to organize injury prevention activities at the local level and worked with the MCH Branch to organize the annual injury prevention conference

b. Current Activities

/2004/ In 1998, the death rate due to motor vehicle accidents was 2.8 per 100,000 0-14 year olds. Since 1997 and through 2001, the rate has been relatively steady, fluctuating between 2.7, the rate in 2000, and 2.9, the rate in 1997, 1999, and 2001. For 2001, the annual objective of 2.6 was not met. //2004//

/2004/ Current efforts to address this problem include the California Safe Communities Program, a joint state-local public health and traffic safety initiative intended to promote new partnerships between traffic safety and health experts. CCCIP at San Diego State University serves as a resource center on child and adolescent injury prevention and continues to provide data and technical assistance in the development, implementation and evaluation of injury prevention programs. They also serve to create linkages between agencies, researchers, and advocates. To raise funds to support child injury and abuse prevention programs, the State sells special car license plates, "Kid's Plates"; An updated statewide list of current locally operated child safety seats programs for use by traffic courts, community agencies, hospitals and clinics is available online at http://www.dhs.ca.gov/ps/cdic/epic. //2004//

c. Plan for the Coming Year

/2004/ In 2002, CIPPP in collaboration with the MCH Branch started a bi-monthly teleconference with the currently funded five counties (Alameda, Kern, Humboldt, San Mateo, and Sonoma) for child passenger safety professionals that enable statewide networking, joint planning, and skill development. This group then expanded to include other interested MCAH programs. Topics discussed include the "Incorporating Injury Prevention into Programs Serving Women, Children, and Adolescents" booklet, Walk to School Day, California's Poison Control System, Kids Plates, and legislative injury prevention updates. These teleconferences will continue in 2004. In addition, a list serve was started with the five funded programs and expanded to include a total of 23 MCAH jurisdictions. The list serve will be used to give updates, alert programs of funding sources, and share information. In addition, CIPPP will continue to produce the Safety Literature updates with weekly references of current injury prevention articles.//2004//

/2004/ CIPPP made site visits with the MCH Branch to all five funded MCAH jurisdictions to develop community injury prevention strategic plans and coordinate partnerships with multiple programs and agencies around childhood injury prevention. Other county MCH programs are also implementing injury prevention activities: Santa Clara has formed a drowning prevention workgroup; Del Norte worked on maternal and child health and safety project in collaboration with the local Red Cross during a fire disaster in the summer 2002; Shasta County has been involved in a campaign working with teens on issues concerned with driving smart, driving sober, and the effects of riding with someone who is under the influence; and Fresno County has also developed Injury Prevention strategic plans. Many counties are also participating in the Safe Kids Coalitions, child passenger safety checks,

and bicycle helmet education programs. //2004//

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

Increasing the proportion of mothers who breastfeed their infants continues to be a Title V priority for the period 2001-2005. Progress is monitored in National Performance Measure 11, formerly Federal Performance Measure 9. In California, the measure examines the percent of women who report intending to exclusively breastfeed their infant upon hospital discharge. Exclusive breastfeeding is defined as the infant receiving breast milk, and no other fluids or solids, with the exception of vitamins, minerals, water, juice, or cultural feeds given infrequently. The 1998 annual objective of 42.3 percent of women intending to exclusively breastfeed upon hospital discharge was achieved. Modest progress has been seen from 1996-1998, with an increase from 41.8 percent to 43.5 percent.

/2002/ FPM #9, showed no improvement from 1998 to 1999 (43.5 vs. 42.9). Consequently, the 1999 annual objective of 44.0 percent was not achieved. The State Breastfeeding Committee will review this data in order to identify additional strategies to achieve progress in early initiation of exclusive breastfeeding. In addition, data from the California Maternal and Infant Health Assessment are being used to identify the barriers to breastfeeding and better understand current infant feeding practices. Revised educational materials with updated information have been developed for CDAPP providers.

/2003/ Federal Performance Measure 9, has shown no improvement from 1999 to 2000, 42.9 percent vs.42.6 percent. Consequently, the 2000 annual objective of 44.1 percent was not achieved. The prevalence of exclusive breastfeeding has been relatively stable since 1996 when 41.8 percent of women breastfed exclusively at hospital discharge.

/2003/The DHS (MCH, WIC, and CMS Branches, and Licensing and Certification Division) is identifying strategies to improve breastfeeding rates prior to hospital discharge. A focus of this effort is to promote the revision of the State regulations addressing hospital policies which affect breastfeeding. To facilitate breastfeeding among women who return to work after childbirth, Governor Davis signed AB1025 which requires all California employers to provide a reasonable amount of break time to accommodate an employee wishing to express breast milk, and to make a reasonable effort to provide a room in close proximity to the work area for expressing milk. A fine of $100 for each violation is stipulated.

/2003/ Working with CalSAFE, CalLEARN and AFLP, DHS is insuring that teen pregnancy programs effectively promote breastfeeding among this age group of mothers that is less likely to breastfeed. In the MCH Branch, based on finding that African American women are less likely to initiate or sustain breastfeeding than White or Hispanic women, strategies for BIH program collaboration with local breastfeeding coalitions have been promoted and adopted in several counties.

b. Current Activities

/2004/ National Performance Measure 11 (formerly Federal Performance Measure 9), the percent of mothers who exclusively breastfed their infants at hospital discharge, remained relatively constant in 2001; 42.2 percent of mothers exclusively breastfed their infants in 2001 compared to 42.6 percent in 2000. The annual objective of 44.8 percent was not achieved.//2004//

/2004/ DHS continues many efforts to improve the number of women who exclusively breastfeed. CDAPP has added a chapter on breastfeeding to its Guidelines for Care for women with gestational diabetes, as well as for those who take insulin and breastfeed. CDAPP staff continue to participate in professional organizations, meetings, and produce publications about the benefits of breastfeeding for both mother and child in reducing the risk for diabetes. The BIH held a meeting of program coordinators to focus on topics pertinent to increasing breastfeeding among African American women. DHS held a statewide Public Health Grand Rounds session, "Breastfeeding and the Law that Helps"; this session was attended by at least 154 participants. The presentation provided a review of the importance of exclusive breastfeeding and what health care professionals can do to support increasing exclusive breastfeeding in their communities. The WIC Branch has completed the results of the Infant Feeding Policies and Practices Survey distributed to all hospitals in California. The survey results identified those labor and delivery services policies and practices associated with higher exclusive breastfeeding rates. //2004//

c. Plan for the Coming Year

/2004/ The Statewide Breastfeeding Promotion Advisory Committee is working to revise Model Hospital Policies that provide information and guidance to perinatal professionals. The committee has also been working with the Medi-Cal program to improve reimbursement for lactation services and lactations aids, such as breast pumps. The MCH Branch staff is involved with promoting local breastfeeding coalitions, including participating with a planning team from the University of California, Davis for a Statewide Breastfeeding Coalition Conference which will bring together local breastfeeding coalitions in an effort to collaborate and share successful initiatives. //2004//

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

a. Last Year's Accomplishments

National Performance Measure 12, formerly Federal Performance Measure 10, is the percent of newborns that have been screened for hearing impairment before hospital discharge.
/2002/ The NHSP is currently adding hospitals into the CCS NHSP system. However, in 1999, the hospitals doing universal screening were not being tracked by the NHSP. Birth records from these hospitals indicate that they accounted for 51,000 (or 9.8 percent) of the current births in California (32). Performance on FPM 10 fell just below the projected target for the year.
/2003/ Birth records from hospitals known to be performing universal screening in 2000 indicate that 73,170 infants or 13.7 percent received hearing screening prior to hospital discharge. Data in future years will be collected from the NHSP rather

than estimated from the hospital birth data. The NHSP Hearing Coordination Centers (HCCs) are providing assistance to hospitals in the development and maintenance of their screening programs and in tracking and monitoring infants needing outpatient follow-up, diagnostic evaluations, and early intervention. In states without this infrastructure, up to 50 percent of infants who need follow-up care do not receive it. The NHSP management system was discontinued in December 2001. Through December 2001, NHSP had screened 54,000 infants and identified hearing loss in 210, half of whom were diagnosed before three months of age (36).

b. Current Activities

/2004/ This Federal Performance Measure 10 has been renumbered as National Performance Measure 12. For FY 2001, based on birth records from hospitals known to be performing universal screening and those that were certified to participate in the NHSP, it is estimated that approximately 114,166 infants or 21.6 percent received hearing screening prior to hospital discharge. Until an automated data management system is developed, data regarding newborn hearing screening will continue to be estimated using this methodology. This percentage was an increase of 58 percent from FY 2000 and well over the objective of 15 percent. The annual performance objectives have been increased to reflect the anticipated number of hospitals screening infants in the coming years. Current activities to enhance this performance measure include: 1) trainings on infant diagnostic audiology evaluations for community audiologists; 2) educational programs for primary care providers regarding their role as a medical home in the NHSP; 3) participation on the Deaf and Hard of Hearing Early Intervention Workgroup to research and recommend statewide standards for parent-infant curriculum and methodology-neutral language assessment for use in the Early Start programs. //2004//

/2004/ Since the discontinuation of the electronic NHSP data management system on December 31, 2001, the NHSP has been utilizing a paper reporting system which affects the program's ability to accurately report the number of infants who receive screening, those who need follow-up, those identified with hearing loss, and those who have entered early intervention services. Certified inpatient and outpatient screening providers as well as diagnostic audiology providers report to the regional HCCs on standardized reporting paper forms. While the State program has no capacity for electronic data submission, it continues to receive aggregate data reports from the HCCs quarterly. //2004//

 View Attachment

c. Plan for the Coming Year

/2004/ The NHSP was required to implement a reprocurement process for the new HCC contracts that began July 2002. This has resulted in a change in the HCC contractors serving the three regions in southern California. HCCs will be in place in all five regions of the state effective July 2003. //2004//

/2004/ All of the CCS approved hospitals in northern California were certified to participate in the NHSP by mid-February 2003. Due to a lack of staff to perform technical assistance and certification activities in the southern California regions, over 40 hospitals are yet to be certified in those regions. These hospitals are expected to be certified in 2004. //2004//

/2004/ CDE and the NHSP were awarded a grant by the Maternal and Child Health Bureau to fund the continuation of training audiologists and primary care providers regarding the NHSP, and the development of statewide standards for parent-infant curriculum and language assessments of infants with hearing loss for utilization in Early Start programs. //2004//

Performance Measure 13: *Percent of children without health insurance.*

a. Last Year's Accomplishments

Data from the Health Insurance Policy Program at UCB/UCLA provides an estimate of the percent of children in California who are uninsured for National Performance Measure 13, formerly Federal Performance Measure 12. In 1998, this figure increased to 21.0 percent from the 1997 level of 18.3 percent. Consequently, the 1998 objective was not reached. In future years, gradual reductions in the percent of uninsured children are anticipated because of California's commitment to the expansion of the Healthy Families Program and the enrollment of Medi-Cal eligible children in the Medi-Cal program. The California budget for FY 2000-2001 eliminated the quarterly status Report to contribute to increased continuity of Medi-Cal coverage.

/2002/ The percent of children who were uninsured, Federal Performance Measure 12, declined in 1999 to 19.0 percent, compared with 21.0 percent reported in 1998. The annual objective of 19.0 percent was achieved. The improvement is likely to reflect, at least in part, the impact of the State's major outreach initiatives to enroll eligible children in the Healthy Families and Medi-Cal programs.

/2003/ The percent of children who were uninsured, Federal Performance Measure 12, declined in 2000 to 15.7 percent, compared with 19.0 percent in 1999. The annual objective of 18.0 was achieved. Both the State's efforts to enroll eligible children in Medi-Cal and HFP along with the strong California economy in 2000 appear to have contributed to expanded child health insurance coverage.

b. Current Activities

/2004/ National Performance Measure 13, formerly Federal Performance Measure 12, the percent of children who were uninsured declined slightly in 2001 to 15.3 percent, compared to 15.7 percent in 2000. The annual objective of 16.2 was achieved. The State's continued and increased efforts to encourage enrollment of eligible children into Medi-Cal and the HF Program through such efforts as public awareness media campaigns, community education and assistance, simplification of the application processes for both programs, and improvements in the Medi-Cal eligibility determination process appear to have contributed to the continued decline in uninsured children in California. Additional decreases in numbers of uninsured children are expected with the implementation of the CHDP Gateway Program and especially with the provision of information and materials in multiple languages. However, the budget constraints in California may negatively impact the number of uninsured children in the future.//2004//

/2004/ Beginning July 1, 2003, the CHDP program will serve as a gateway to HF and Medi-Cal health coverage, potentially enabling approximately 760,000 children to receive full health care coverage. Through the CHDP Gateway, each child under

19 years old with family income at or below 200 percent FPL (and not already in the MEDS system) will be "presumed eligible" for Medi-Cal or HF and immediately be given a temporary Medi-Cal Benefits Identification Card (BIC) number. With this BIC number, a child will have no-cost, full-scope fee-for-service Medi-Cal benefits for up to 60 days. //2004//

c. Plan for the Coming Year

/2004/ Current Activities and Plan for the coming year include: 1) Enrollment into HF, AIM, and Medi-Cal programs through such efforts as public awareness media campaigns and other community education and assistance efforts to increase health care access. 2) Develop and implement CHDP Gateway and related trainings to enroll eligible children in Medi-Cal or HF including provision for information and materials in multiple languages. 3) Simplify HF and Medi-Cal application processes such as online application Health-e-App and mail-in application. 4) Implement and support improvements in Medi-Cal eligibility process such as continuous eligibility for children. //2004//

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

The percent of potentially Medicaid eligible children receiving services paid by the Medicaid program, National Performance Measure 14, formerly Federal Performance Measure 13, is based in part on data from a new data system being developed by the State. In 1998, 54.2 percent of the potentially Medicaid eligible received a service paid for by Medicaid. The objective for 1998, 60.0 percent, was not achieved. Since data from prior years were based on a different data source, earlier figures are not comparable. Based on the outreach activities undertaken by the State to expand enrollment of the Medi-Cal eligibles, increases in the percent of eligibles that receive a service are anticipated in the period from FY2001-2005.

/2002/ The percent of potentially Medicaid-eligible children who have received a service paid for the Medicaid program, Federal Performance Measure 13, was 62.9 percent in 1999. The methodology used to calculate the measure changed in 1999. Consequently, this figure should not be compared with prior years. The annual objectives have been adjusted to take into account the 1999 data. Improvements in access to care among California's low-income children are anticipated with the expanded outreach initiatives for enrollment in the Healthy Families and Medi-Cal programs.

/2003/ The percent of potentially Medicaid-eligible children who have received a service paid for the Medicaid program, Federal Performance Measure 13, was 60.8 percent in 2000. The annual objective was not achieved. While Medi-Cal enrollment for children did increase slightly in the last year, it is not known why service utilization did not increase. One possible explanation is limited access to providers who will accept Medi-Cal.

b. Current Activities

/2004/ National Performance Measure 14, formerly Federal Performance Measure 13, the percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program, increased slightly in 2001 to 60.9 percent, compared to 60.8 in 2000. The annual objective of 60.3 was achieved. The estimated number of uninsured children eligible for Medicaid in California increased from 726,000 in 2000 to 768,000 in 2001 while the number of enrolled Medicaid eligible children decreased about 20,000 from approximately 3.58 million in 2000 to 3.56 million in 2001. One possible reason for the small decrease in the number of enrolled children is that for this period of time, the number of eligible children enrolled was still being affected by additional persons being discontinued from the public assistance program, CalWORKS. //2004//

/2004/ The reported number of children in California who received a service paid by Medicaid increased about 20,000 from approximately 2.62 million in 2000 to 2.64 million in 2001. The reason for the slight increase is unknown but may be due to the many outreach efforts underway to encourage families and adolescents to access the Medi-Cal system and obtain services needed. //2004//

/2004/The State has made a strong commitment to reduce the number of uninsured California children. Activities include: 1) continued support of streamlined Medi-Cal eligibility processes that encourage continuous coverage; 2) continued support for client case management by MCH programs such as the AFLP and BIH to screen and assess children and adolescents for Medi-Cal eligibility and coverage and services needed and assist them in obtaining services needed; 3) continued public education media campaigns and other community education efforts to encourage eligible families to obtain medical services, such as family planning visits, well baby visits, prenatal care visits, childhood immunizations, and dental care visits; and 4) facilitation of the provision of Medicaid paid prenatal care services to adolescents by providing financial incentives to prenatal care providers. //2004//

c. Plan for the Coming Year

/2004/ Implementation of the CHDP Gateway is DHS' primary emphasis for assuring that Medi-Cal eligible chilren receive services. //2004//

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

The percent of VLBW infants born to resident women in California, National Performance Measure 15, formerly Federal Performance Measure 15, remained relatively stable at 1.0 – 1.2 per 1,000 live births from 1989 –1998. Consequently, the 1998 annual objective, which reflected maintenance of the 1997 figure, was not achieved. An analysis of the percent of VLBW infants among singleton births, Health Status Indicator 5B, reveals a stable figure of 0.9 VLBW newborns per 1,000 live births from 1997 to 1998.

/2002/ Federal Performance Measure 15, was 1.1 percent, falling slightly from 1998, to the figure observed in 1996 and 1997. California continues to build on its efforts to improve the quality of maternity and prenatal care for all women.

/2003/ Federal Performance Measure 15, remained at 1.1 in 2000. The annual

objective of 1.2 percent was achieved.

California continues to strive to reduce the percent of VLBW newborns through increasing entry into prenatal care during the first trimester of pregnancy, assuring the delivery of newborns of high-risk women in appropriate facilities, and quality improvements in perinatal hospital services. Nevertheless, until the causes of preterm birth are better understood, new interventions developed, and the use of reproductive technologies stabilizes, a decline in the overall percent of VLBW infants is not likely to be observed.

/2003/ The MCH and CMS Branches are involved in many programs that seek to improve the quality of prenatal care that is provided to women at-risk of poor birth outcomes, such as very low birth weight newborns. Among these are CPQCC, CPSP, AFLP and BIH. The two Branches will continue to invest and collaborate in these programs. Improved access to family planning services, to avoid unwanted pregnancies through such programs as Family PACT may also improve birth outcomes. The recent BIH evaluation, dated 1994-1998, showed that the program was effective in reducing the rates of very preterm delivery and very low birth weight among very high-risk women and their newborns. The extent to which the percent of VLBW infants can be reduced is not known in light of the limited understanding of the causes of preterm birth and the fact that women are adopting reproductive technologies that increase the incidence of multiple births.

b. Current Activities

/2004/ National Performance Measure 15 (formerly Federal Performance Measure 15), the percent of very low birth weight live births was 1.1 percent in 2001, meeting the annual objective of 1.2 percent. Stable rates since 1996 have coincided with strong programmatic efforts throughout California to focus on early prenatal care and adequate delivery for expectant "at-risk" mothers. With 1,534 Medi-Cal obstetrical providers currently approved for the provision of CPSP services and approximately 150,000 women served, concerted outreach within the health care system has been particularly helpful in advocating for comprehensive perinatal services for all eligible women. Quality improvement through RPPC funded programs and CPQCC have also contributed to meeting this objective. //2004//

/2004/ The percentage of very pre-term delivery in 2001 was more than two times greater for African Americans than non-Hispanics Whites and is a reflection of on-going health disparities within the state. BIH programs are invaluable in identifing parenting African American women who could benefit from education, empowerment, and much needed support. //2004//

/2004/ Current activities include: 1) RPPC assure access to risk-appropriate perinatal care while providing quality improvement activities at delivery hospitals and working to connect agencies, providers, and individuals. 2) CPSP works to decrease the incidence of low birth weight infants by providing Medi-Cal eligible women with comprehensive services including prenatal care, education, and psychosocial support. 3) With a more than double the risk of low birth weight among African-American infants, BIH programs throughout California help identify at-risk pregnant African-American women to provide education and case management and increase first trimester prenatal care. 4) CPQCC advocates for performance improvements in perinatal and neonatal outcomes through data driven strategies and collaborative efforts with health agencies within California. The CPQCC disseminates tool kits and other quality improvement strategies to improve neonatal

care in California. //2004//

c. Plan for the Coming Year

/2004/The MCH Branch has partnered with the CPSP coordinators to better address the needs of local practitioners and CPSP clients. MCH will continue to initiate, support and develop opportunities to make particular programs more culturally relevant. Contra Costa County Health Department distributed the Steps to Take (STT) Guideline Client Handouts in English, Spanish, Vietnamese, and Lao. SIDS materials were provided in Farsi, Hmong, Lao, Russian, Spanish, Vietnamese, and Tagalog. The MCH Branch plans to disseminate Contra Costa's material to all PSCs and CPSP providers at the local level to enhance the services provided by CPSP practitioners. //2004//

/2004/ The MCH Branch is continuing its contract to develop the training and materials contract with Mt. San Antonio College, Walnut, California. The MCH Branch has asked the CPSP contractor to focus on maintaining the quality of training and materials. //2004//

/2004/ BIH is also working to develop partnerships with regional and national organizations and is in the formative stage(s) of developing a collaboration with the March of Dimes to expand their Prematurity Prevention Campaign. The campaign aims to promote the "Guidelines to Prevent Prematurity" developed by Kern County under contract with the BIH Program. Local health jurisdictions are being targeted to increase awareness about preventing prematurity in the African-American community. Also, the USDA Nutrition Network is funding the production of "Preventing Iron-Deficiency Anemia", educational materials targeted at the African-American community. Materials will be provided to local BIH, CHDP, WIC and MCH Branch programs. //2004//

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

a. Last Year's Accomplishments

The rate of suicide deaths among youth aged 15 through 19, National Performance Measure 16 and formerly Federal Performance Measure 16, continued to decline from 7.1 suicide deaths per 100,000 youth 15 through 19 years old in 1997 to 6.3 deaths in 1998. The 1998 objective of 8.5 deaths per 100,000 was achieved. Over the period of 1990-98, a statistically significant downward trend has been observed in the adolescent suicide rate, which fell from 9.2 to 6.3 deaths per 100,000 youth 15 through 19 years old. Continued improvement is projected for the period of 2001-2005. The Department of Mental Health and the California Liaisons for Adolescent Suicide Prevention (CLASP) will continue to develop strategies for coordinating efforts to address the problem of adolescent suicide.

/2002/ FPM 16, the adolescent suicide rate, was 4.6 suicide deaths per 100,000 youth aged 15 through 19 years old in 1999. The 1999 objective of 6.0 was achieved and surpassed. Caution should be applied in comparing 1999 mortality-related measures to rates prior to that year because of the uncertainty regarding the comparability of data resulting from the shift from the ICD9 codes used through 1998 to the ICD10 codes used in 1999. Developing opportunities for adolescent

participation in their communities and other asset-based interventions along with expanded access to mental health services are expected to contribute to further reductions in the adolescent suicide rate.

/2003/ Federal Performance Measure 16, was 5.4 in 2000. As seen in the adolescent homicide death rate, the downward trend in the suicide death rate was not maintained in 2000. The annual objective was not achieved. Current efforts to improve health care coverage and growing attention to the need for expanded access to appropriate mental health services can help prevent adolescent suicide deaths.

Adolescent health issues are a growing concern at the State and local level. The Adolescent Health Collaborative, a broad-based, statewide group with representatives of the public and private sectors, identified the need for a comprehensive plan for addressing the health and developmental needs of California's adolescents. In response to this need, the California MCH Branch contracted with staff of the National Adolescent Health Information Center of the University of California at San Francisco, to develop a strategic plan. The document provides background information and recommendations for future directions for the adolescent health programs in California. The recommendations focus on the assets and needs of adolescents. The The MCH Branch is reviewing the plan in order to identify strategies for strengthening its programs to improve adolescent health services particularly through the incorporation of an assets-based approach to health promotion.

b. Current Activities

/2004/ National Performance Measure 16 (formerly Federal Performance Measure 16), the adolescent suicide rate, was 5.1 suicide deaths per 100,000 youths aged 15 through 19 years in 2001. The annual objective of 5.9 was achieved and surpassed. A related Healthy People 2010 Objective is to reduce the rate of suicide attempts by 9th through 12th graders to a 12-month average of one percent. In FFY 2000, the downward trend in the suicide death rate did not continue as compared with previous years. However in FFY 2001, the downward trend resumed. Explanations for this reversal could be due to increased efforts to extend adolescents' access to mental health services. //2004//

/2004/ Suicide is one of the leading causes of death among American youth; as a result California is looking at ways to improve adolescent mental health. The MCH Branch is working with the National Adolescent Health Information Center (NAHIC) and the Adolescent Health Collaborative (AHC) to develop a capacity for increased coordination between primary care, mental health, and schools. The AHC composed of many stakeholders met in December 2002 and focused on adolescent mental health issues related to prevention and early intervention. Stakeholders met for joint education, discussion, and brainstorming activities with a common goal of increasing adolescents' access to preventive and early intervention mental health services. The goal was to develop capacity and increased coordination between primary care, mental health, and schools. //2004//

c. Plan for the Coming Year

/2004/ The State Adolescent Health Coordinator has been working with the Medi-Cal Program, the University of California, San Francisco, and the Adolescent Health Working Group on a quality improvement project to improve adolescent

health preventive services for teens. A recent survey on adolescent health was sent to the Medi-Cal Medical Directors, which will be used in setting priorities for the quality improvement project. The State Adolescent Health Coordinator is also collaborating with the State Injury Prevention Director on areas around youth injury prevention. //2004//

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

a. Last Year's Accomplishments

By 1998, 64.6 percent of California's VLBW newborns were delivered in facilities for high-risk deliveries, National Performance Measure 17, formerly Federal Performance Measure 17. The annual objective of 60.6 percent was achieved. The 1998 figure is based on data from hospitals designated by the CCS program as Regional or Community NICU facilities. However, not all facilities providing care for VLBW infants seek certification by CCS. California's efforts to improve access to the appropriate level of facility include; encouraging all hospitals functioning as high-risk facilities to seek CCS designation, developing collaborative hospital relationships through the CCS program, and outreach and education by the RPPCto encourage appropriate referrals. In light of these continuing activities, further improvement is expected in this measure over the period of FFY 2001-2005.

The RPPC seek to improve the quality of risk-appropriate perinatal care through regional coordination. Two Regional Perinatal Dispatch Centers coordinate transport of pregnant women and ill neonates to centers that provide varying levels of intensive care. The dispatch centers also track the types of transports, frequency and location of services. This allows an overview of maternal and infant problems necessitating higher levels of care and the patterns of flow of health care requiring movement away from local facilities. Annual data is also submitted by CCS approved nurseries on infants requiring intensive care at the intermediate and higher levels. Combined with vital statistics information, this provides an overview of infant health and morbidity, not just mortality.

/2002/ In 1999, 65.4 percent of California's VLBW newborns were delivered in facilities for high-risk deliveries. This figure, which rose from the 64.6 percent observed in 1998, was slightly below the 1999 annual objective of 65.6 percent. In June 2001 the CPQCC initiated annual NICU data reporting to CCS for the first cohort of participating nurseries. Annual reporting is required for continuing CCS approval and reporting through the CPQCC is expected to facilitate data submission and analysis and improve reporting accuracy.

/2003/ In 2000, 65.9 percent of California's VLBW newborns were delivered in facilities for high-risk deliveries, Federal Performance Measure 17. The annual objective was not achieved.

b. Current Activities

/2004/ National Performance Measure 17 (formerly Federal Performance Measure 17), the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates, was 65.6 percent in 2001. The annual objective of 66.5 percent was not met. Continuing efforts to improve the outcome for this measure

include: 1) CPQCC seeks to improve patient care and efficient resource allocation and utilization through collaborative efforts; 2) CCS provides services for infants who suffer complications as a result of premature birth and encourages delivery at appropriate facilities through regional cooperatiuon agreements among hospitals; 3) CCS certifies neonatal intensive care units 4) RPPCs ensure access to appropriate care and ensure safe treatment of women and their infants. //2004//

c. Plan for the Coming Year

/2004/ CPQCC prepares the data reports on clients and their neonatal care for CCS for those NICUs participating in CCS/CPQCC joint reporting. This collaboration offers CCS a meaningful and uniform reporting scheme with which to assess hospitals for comparitive purposes on level of care for neonates. Currently there are 60 hospitals enrolled in CPQCC. Approximately 30 additional hospitals are in various stages of the CPQCC membership application process as CCS NICU annual data submission through CPQCC becomes mandatory for infants admitted to CCS approved NICUs beginning in January 2004. This new policy will double the number of participating hospitals by 2005. The California Perinatal Dispatch Center was renamed the California Perinatal Transport System (CPeTS) this fiscal year to better reflect the activities they provide. The Southern California system is administered by a a new contractor, This contractor brings a new data consultant and Web Master. Hospitals will be trained to self-report bed availability and a program for real time data reports is currently being developed. //2004//

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

a. Last Year's Accomplishments

Improving access to first trimester prenatal care, National Performance Measure 18, formerly Federal Performance Measure 18, has been a long-term MCH priority. In 1998, 82.4 percent of women entered prenatal care in the first trimester, meeting the annual objective of 82.1 percent. The marked reduction in the disparity between Medi-Cal and non-Medi-Cal insured women, Core Health Status Indicator 6 C, is also noteworthy. The absolute difference between the two groups in relation to first trimester entry into care was 29 percent in 1989, and fell to 15 percent in 1998. Continued improvement is anticipated based on the education and outreach efforts by the State and the local MCH jurisdictions, including the activities of such Title V programs as the Regional Perinatal, Black Infant Health, and Adolescent Family Life Programs.

/2002/ In 1999, California continued the steady improvements in access to first trimester prenatal care that have been reported since 1996. In 1999, 83.6 percent of infants were born to pregnant women who received prenatal care beginning in the first trimester, Federal Performance Measure 18, compared with 82.4 percent in 1998. The 1999 annual objective, 83.9 percent, was slightly higher than the observed measure. Core Health Status Indicator 6 C indicates that in 1999 timely prenatal care improved for both women on Medicaid and those not on Medicaid, although progress was more marked among the former.

/2003/ In 1999, Federal Performance Measure 18 rose to 84.5 percent, up from 83.6 percent. The 2000 annual objective was achieved. Outreach to promote timely prenatal care is a component of numerous programs including Baby CAL and BIH.

The local health departments conduct outreach to pregnant women through the Perinatal Outreach and Education Program. Improving the quality of services through such programs as BIH, CPSP, AFLP and CDAPP can also increase timely enrollment. Nevertheless, until delays in prenatal Medi-Cal coverage are reduced and/or more low-income women are aware that Medi-Cal Presumptive Eligibility will insure that their initial costs of prenatal care are covered by Medi-Cal, and the percent of unintended pregnancies remains high, some pregnant women are likely to enter prenatal care after the first trimester.

b. Current Activities

/2004/ National Performance Measure 18, formerly Federal Performance Measure 18, the percent of infants born to women who received prenatal care in the first trimester, continued to rise from 84.5 percent in 2000 to 85.4 percent in 2001. The annual objective of 85.0 was therefore met. Given the current trend over the last five years, California should meet the Healthy People 2010 objective of 90 percent before 2010. //2004//

/2004/ DHS facilitates the advancement towards this objective through programs such as BIH, CPSP, and AIIHI. BIH and CPSP target specific populations: African-American women and low-income pregnant women through prenatal care education and awareness of support services. The AIIHI targets prenatal and parenting American Indian women and their families for case management services and linkages to medical care. The MCH Branch works to provide ethnically diverse staff for recruiting clients into care, while local MCH jurisdictions operate to employ a variety of unique methods to target diverse populations. The MCH program in Orange County utilized matching funding through the First Five program to conduct care coordination for pregnant women and their families. The program, called "Promotores", works with Hispanic pregnant women and their families to ensure that they are enrolled in prenatal care and have access to all appropriate services such as WIC and health care for other children in the family. //2004//

c. Plan for the Coming Year

/2004/ DHS will continue to facilitate programs such as BIH, AIIHI, and CPSP to improve access to prenatal care. //2004//

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g.				

phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State				
1. Purchase of phenylketonuria formula and food products for individuals.	☑	☐	☐	☐
2. Contracts providing statewide coverage for consultation for related metabolic conditions.	☐	☐	☐	☑
3. Development of a data system linking newborn screening records with birth certificates.	☐	☐	☑	☐
4. Arranging transportation, as needed, to access follow-up services.	☐	☑	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. CISS Grant Family-Centered Survey data analysis.	☐	☑	☐	☐
2. Development of CCS program policy letter for FCC for county programs.	☐	☐	☐	☑
3. Development of FCC Training Guide for County CCS programs.	☐	☐	☐	☑
4. Counties implementing new CCS Staffing Standards for inclusion of a parent liaison.	☐	☐	☐	☑
5. CCS conducts transition planning trainings.	☐	☐	☐	☑
6. Medical Therapy Program activities on transition planning and family-centered care.	☐	☑	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing,				

comprehensive care within a medical home. (CSHCN Survey)				
1. Collaboration with California Medical Home Project targeting CCS children.	☐	☑	☐	☐
2. Involvement in the LA Medical Home Project.	☐	☑	☐	☐
3. LA Care & Health Net Medi-Cal Managed Care Plans partnering with LA County CCS.	☐	☐	☐	☑
4. Info sharing between LA CCS Automated Case Management System & LA Care Medi-Cal Managed Care Plan.	☐	☑	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Implementation of CHDP Gateway to enroll eligible children in Medi-Cal or HF.	☐	☑	☐	☐
2. Statewide trainings & video teleconferences on Gateway for State & local CHDP staff & providers.	☐	☐	☐	☑
3. Continuation of the CAI that enrolls uninsured children under 5 yrs old into the ATS Project.	☑	☐	☐	☐
4.	☐	☐	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				

1. Development of CCS program policy letter for Family Centered Care (FCC).	☐	☐	☐	☑
2. Counties' implementation of outpatient mental health CCS program policy letter.	☐	☐	☐	☑
3. Review of all CCS approved facilities for implementation of FCC.	☐	☐	☐	☑
4. Development of FCC Training Guide for county CCS programs.	☐	☐	☐	☑
5. Support for local CCS program innovative projects to coordinate services.	☐	☐	☐	☑
6. Revision and reissuance of the CMS and DDS Interagency Agreement.	☐	☑	☐	☐
7. Issuance of the Early Start and CMS Interagency Agreement.	☐	☑	☐	☐
8. Participation on interagency committee addressing collaboration of foster care system redesign.	☐	☐	☐	☑
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Forming workgroup to develop and implement written policy for transitioning care.	☐	☐	☐	☑
2. Review of all CCS approved facilities for implementation of transition care planning.	☐	☐	☐	☑
3. Continued trainings on transition services begun in the San Francisco Bay Area.	☐	☐	☐	☑
4. County programs to either continue or initiate transition service planning.	☐	☐	☐	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against				

Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. HS, HIPC & AIM provide health care access including immunizations for children.	☐	☑	☐	☐
2. HF enrolling children not eligible for private or Medi-Cal coverage.	☐	☑	☐	☐
3. 9 regional immunization registries exchanging immunization data.	☐	☐	☐	☑
4. Health promotion for adequate immunizations through BIH, CPSP, and CHDP gateway.	☐	☐	☑	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. AFLP and ASPPP case management services to pregnant and/or parenting teens.	☐	☑	☐	☐
2. OFP providing clinical family planning services through the Family PACT.	☐	☑	☐	☐
3. Information and Education Program providing community-based educational services.	☐	☐	☑	☐
4. Male Involvement Program providing community-based educational services.	☐	☐	☑	☐
5. Community Challenge Grant Program providing community-based educational services.	☐	☐	☑	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. WIC and MCH jointly providing toothbrushes and toothpaste				

to program participants.	☐	☑	☐	☐
2. Distribute a brochure and poster focusing on oral health and nutrition.	☐	☐	☑	☐
3. Working on RFA by First Five Commission for Children's Oral Health Initiative.	☐	☐	☐	☑
4. Increase fluoridation of State water supply.	☑	☐	☐	☐
5. MCH Oral Health Policy Consultant providing technical assistance for the Branch.	☐	☐	☐	☑
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. CSCP promoting public health and traffic safety initiative.	☐	☐	☐	☑
2. CSCP promoting new partnerships between traffic safety and health experts.	☐	☐	☐	☑
3. CCCIP providing data and technical assistance in the development of injury prevention programs.	☐	☐	☐	☑
4. CCCIP implementing and evaluating injury prevention programs.	☐	☐	☐	☑
5. CCCIP creating linkages between agencies, researchers, and advocates.	☐	☐	☑	☐
6. Use money from special license plates (Kids' Plates) for child injury & abuse prevention programs.	☐	☐	☑	☐
7. Provide and update statewide lists online of local child safety seat programs.	☐	☑	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. CDAPP expanding patient education materials on breastfeeding.	☐	☑	☐	☐

2. BIH coordinators developing strategies for increasing breastfeeding among African American women.	☐	☐	☐	☑
3. Planning a statewide Breastfeeding Coalition Conference.	☐	☐	☐	☑
4. The Statewide Breastfeeding Promotion Advisory Committee (SBPAC) revising Model Hospital Policies.	☐	☐	☐	☑
5. SBPAC working with Medi-Cal program to improve reimbursement for lactation services and aids.	☐	☐	☐	☑
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Trainings on infant diagnostic audiology evalutions for community audiologists.	☐	☐	☐	☑
2. Educational programs for primary care providers on role as medical home in NHSP.	☐	☑	☐	☐
3. Participation on the Deaf and Hard of Hearing Early Intervention Workgroup.	☐	☐	☐	☑
4. HCCs assist hospitals & track and monitor infants needing follow-up/evaluation/intervention.	☐	☐	☑	☐
5. Certification of 40 hospitals in Southern California.	☐	☐	☐	☑
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Encouraging enrollment in HF, AIM, and Medi-Cal via education and assistance efforts.	☐	☐	☑	☐
2. Implement CHDP gateway to enroll eligible children in Medi-Cal or HF.	☐	☐	☐	☑
3. Working to provide information and materials in multiple languages in CHDP Gateway.	☐	☐	☐	☑

4. Continue simplification of HF and Medi-Cal application processes for online & mail-in applications.	☐	☑	☐	☐
5. Continue to implement and support improvements in Medi-Cal eligibility process.	☐	☑	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Continued support of streamlined Medi-Cal eligibility processes.	☐	☑	☐	☐
2. Continued support for client case management regarding facilitating Medi-Cal services.	☐	☐	☑	☐
3. Continued community education efforts related to families getting medical services.	☐	☐	☑	☐
4. Facilitating provision of adolescent prenatal care serivces by Medi-Cal providers.	☐	☑	☐	☐
5. Implementation of CHDP gateway.	☐	☐	☐	☑
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. RPPCs developing and implementing quality improvement activities.	☐	☑	☐	☐
2. CPSP providing comprehensive services to MediCal eligible women.	☐	☑	☐	☐
3. BIH providing education and case management to identified at-risk women.	☐	☑	☐	☐
4. CPQCC collaboration to develop and implement perinatal performance improvement activities.	☐	☐	☐	☑
5. MCH Branch will collaborate with organizations on				

preventing prematurity.	☐	☐	☐	☑
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Work with NAHIC and AHC to increase coordination among primary care, mental health and schools.	☐	☐	☐	☑
2. Work with AHC on adolescent mental health issues, prevention and early intervention.	☐	☐	☐	☑
3. State Adolescent Health Coordinator working on quality improvement teen preventive services project.	☐	☑	☐	☐
4. Collaboration with State Injury Prevention Director on youth injury prevention activities.	☐	☑	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Collaborating with CPQCC to improve patient care & efficient resource allocation & utilization.	☐	☐	☐	☑
2. CCS provides services for infants who suffer complications as a result of premature birth.	☑	☐	☐	☐
3. CCS certifies neonatal intensive care units.	☐	☐	☐	☑
4. RPPCs ensure access to appropriate level care and ensure safe treatment of women and their infants.	☐	☐	☐	☑
5. CCS NICUs report NICU data through CPQCC.	☐	☐	☑	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐

8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. AIIHI serves prenatal and parenting American Indian women for care management.	☑	☐	☐	☐
2. BIH serves African American women through prenatal care education and awareness of support services.	☐	☐	☑	☐
3. CPSP serves low-income women thru prenatal care education and awareness of support services.	☐	☐	☑	☐
4. Local MCH jurisdictions target diverse populations of pregnant women.	☐	☑	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

D. State Performance Measures

State Performance Measure 1: *The percent of children whose family income is less than 200 percent of the Federal Poverty Level who received at least one preventive medical exam during the fiscal year.*

a. Last Year's Accomplishments

SPM #1, addresses the utilization of preventive medical exams by children whose family income is below 200 percent of the FPL. CHDP data is used to calculate this measure.
/2002/ In fund years 1997-1999, the US Census reported that 4,525,000 California children up to 19 years of age were from families with incomes up to 200 percent of FPL. Of these children, 1,876,422 (or 41.5 percent) received preventive medical examinations in FY 1998-1999 through CHDP(13). This includes the Medi-Cal and State-only funded components of CHDP and exceeded the objective on State Performance Measure 1 for the year. However, while improved, this representation of the percent of low-income California children receiving preventive health services remains an underestimate. Healthy Families was enrolling children in FY 1998- 1999 but information on the health services provided is currently unavailable and was not included in the numerator for the calculation of this measure.
/2003/ For fiscal year 1999-2000, 4,330,878 children were the target population for the CHDP program in California with family incomes under 200 percent of FPL. Of these children, 1,848,738, or 42.7 percent, received CHDP preventive medical examinations in FY 1999-2000(7).

This percentage slightly exceeded the objective on State Performance Measure 1 for the year.

b. Current Activities

/2004/ For State Performance Measure 1, in FY 2000-2001, an estimated 4,412,824 children with family incomes under 200 percent of the federal poverty level were the target population for the CHDP program. Of these children, 1,812,655 or 41.1 percent, received CHDP preventive medical examinations in FY 2000-01. This percentage decreased slightly from the FY 1999-00 (42.7 percent) as the target population increased and the number of children receiving CHDP exams decreased slightly. Children who receive preventive health examinations under HF are not included. There continues to be underreporting of encounter data for children enrolled in MCMC plans because the plans do not have incentive for completion of the PM 160 form, the source of CHDP data. Until there is data for HF and better reporting for children enrolled in MCMC, the performance objective cannot be met. However, through outreach efforts of the local CHDP programs and collaboration with the schools and Head Start, it is anticipated that more low-income children will receive preventive exams. Through collaboration with MCMC and HF, it is anticipated that there will be improvements in the collection of data. //2004//

 View Attachment

c. Plan for the Coming Year

/2004/ Outreach efforts to assist children and their families to access preventive health examinations are occurring in local health departments and include health fairs and interagency agreements with WIC and Head Start. Some local CHDP staff participate on the Head Start Advisory Board. CHDP works with school districts to have the first grade exam on record and to complete the CHDP Annual School Report. Local CHDP programs continue to work with providers in their jurisdiction to encourage their provision of preventive services for children from families with incomes at or below 200 percent of the FPL. In areas where access is limited, local CHDP staff work to recruit providers to participate in the CHDP program. //2004//

/2004/ On July 1, 2003, DHS introduced the CHDP Gateway (see State Overview Section for description). HF, the Child Health Insurance Program in California, also provides services to children from eligible families up to 250 percent of the FPL. The data are not reported to the CMS Branch, but will continue to impact the report of the percent of children whose family income is less than 200 percent of the FPL who received at least one preventive medical exam.//2004//

State Performance Measure 2: *The percent of low-income children who are above the 95th percentile of weight-for-length (less than 2 years) or BMI-for-age (2-12 years), or overweight.*

a. Last Year's Accomplishments

/2002/ The SPM measure on children with specific medical conditions has been removed. The State Performance measure on overweight among low-income children, that was introduced last year, has been renumbered as SPM 2.

/2003/ The renumbered SPM 2 (formerly SPM 10) continues to increase and exceeds the annual performance objective for the second year. For FY 2000, 14.9 percent of low-income children 0 to 12 years of age were above the 95th percentile of weight-for-height.

b. Current Activities

/2004/ State Performance Measure 2 is the percent of low-income children 0-12 years who are above the 95th percentile of weight-for-length (<2 years) or BMI-for-age (2-12 years), or overweight. Starting with the year 2000, the data used for this report from the PEDNSS have been updated to utilize the 2000 CDC growth chart percentiles. CDC has also unduplicated the data for FY2001 and this has improved accuracy and resulted in smaller numbers for both the numerator and the denominator. The percentage of overweight children for FY2001 is 17.2 percent, an increase over the 14.9 percent for FY2000. FY2001 is a more accurate estimate, but is 3.2 percent above the performance objective and contributes to the impetus for DHS to identify resources necessary to implement a long-term strategic plan to combat overweight and obesity. A special project funded by the Nutrition Network has been the purchase and distribution of "Go, Glow, Grow" booklets to CHDP providers to give to families at the CHDP health assessment to educate them on the importance of consuming fruits and vegetables, a well-balanced diet, and participating in physical activity. The booklets provide parents with a unique opportunity to not only read to their children, but to learn more about the importance of diet and activity. Through another special project funded by the Nutrition Network, older children and adolescents participating in the CHDP program have received, from health care providers, color brochures of "Food, Activity, and You" (printed in various languages) to educate them about healthy eating, physical activity, and weight management. In January 2003, DHS, with the Center for Weight and Health, convened a biannual statewide conference on childhood obesity prevention. 11,000 participants attended from all states and four other nations.//2004//

c. Plan for the Coming Year

/2004/ Ongoing activities and plans include 1) CMS participation in coalitions on nutrition and inactivity. 2) Participation in Healthy Eating and Childhood Overweight Prevention Grants. 3) Pilot Nutrition Network Project funded nutritionist positions providing nutrition education to low-income families and CHDP providers in Merced and Sonoma Counties in developing community-based coalitions around prevention of childhood obesity and early detection of diabetes, and creative planning and interventions with local schools on weight management. These positions will increase to a total of 10 counties. 4) Continued distribution of Go, Glow, Grow booklets and Food, Activity and You brochures to CHDP providers for children and adolescents. 5) Continued data collection from CHDP nutrition assessments by CHDP providers for infants, children, and adolescents. Data forwarded to the CDC from CHDP health assessments for entry into PEDNSS. 6) State and local CHDP nutritionists develop and implement nutrition education, provide consultation and training to CHDP providers, and coordinate follow-up and referrals to related programs. 7) Assisting with implementation of the biannual California Childhood Obesity Conference sponsored by DHS and the Center for Weight and Health, University of California, Berkeley. //2004//

State Performance Measure 3: *The rate of deaths per 100,000 children aged 1 through 4 years caused by drowning in swimming pools.*

a. Last Year's Accomplishments

The rate of pool drowning among 1-4 year olds, State Performance Measure 3, remained virtually unchanged from 2.05 deaths per 100,000 children 1-4 years of age, in 1997, to 2.06 in 1998. The annual objective of 1.8 deaths per 100,000 was not met. Nevertheless, over the past nine years since 1994, a statistically significant downward trend has been observed. Further improvements are expected with the ongoing efforts of the California Drowning Prevention Network, the training of local Building Code Officials, and the passage of new pool safety legislation (AB3305).
/2002/ SPM 3, the rate of deaths per 100,000 children aged 1 through 4 years caused by drowning in swimming pools, was 2.0 in 1999. The annual objective of 1.8 deaths per 100,000 was not achieved. Caution should be applied in comparing 1999 mortality-related measures to rates prior to that year because of the uncertainty regarding the comparability of data resulting from the shift from the ICD9 codes used through 1998 to the ICD10 codes used in 1999. Local efforts aimed at injury prevention are expected to result in further modest declines.
/2003/ State Performance Measure 3, was 2.2 in 2000 for a total of 48 deaths. The 2000 annual objective was not achieved.

Working with CCIPP and local coalitions, MCH has increased public awareness of the hazards of unprotected swimming pools and promoted legislation to require fencing around swimming pools. CCIPP strategies include the development of coalitions, public awareness promotion, training of professionals and the public, and the development of locally appropriate injury prevention and control programs.

b. Current Activities

/2004/ State Performance Measure 3, the rate of deaths per 100,000 children aged 1 through 4 years caused by drowning in swimming pools, was 2.1 in 2001, slightly higher than the annual objective of 2.0. However, local injury prevention efforts continue to address pool safety interventions. For example, CIPPP worked with Water Watchers to promote drowning prevention activities at the local level. //2004//

c. Plan for the Coming Year

/2004/ DHS will continue to support programs which work to prevent childhood injury including: 1)CIPP which provides data and technical assistance in the development, implementation, and evaluation of injury prevention programs and creates linkages between agencies, researchers, and advocates. 2) Money from the sale of special license plates, called Kid's Plates, which is used to support child injury and abuse prevention programs designed and implemented at the local level. Each county receives its respective share of the money. //2004//

State Performance Measure 4: *The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by homicide.*

a. Last Year's Accomplishments

Since 1994, progress has been achieved in reducing the adolescent homicide rate, State Performance Measure 4. The rate was virtually halved from 1994 to 1998 when it fell from 34.4 deaths per 100,000 15 through 19 year-olds to 17.1. Most recently, the rate of homicide deaths per 100,000 adolescents aged 15 through 19 years fell from 20.4 in 1997 to 17.1 in 1998. The 1998 objective of 20.9 per 100,000 was achieved. The trend in the rate from 1990-98 showed only borderline statistical significance since the decline did not start until 1995. Based on recent figures and the State's passage of strict gun control legislation, further improvements are projected for the period of 2001-2005.
/2002/ SPM 4, reached 13.6 deaths per 100,000 in 1999. The objective of 16.6 was achieved and surpassed. Caution should be applied in comparing 1999 mortality-related measures to rates prior to that year because of the uncertainty regarding the comparability of data resulting from the shift from the ICD9 codes used through 1998 to the ICD10 codes used in 1999. The assets-based development of opportunities for youth will complement the problem- focused responses to such risks as adolescent access to firearms and substance abuse, to contribute to continuing declines in the adolescent homicide rate through 2006.
/2003/ State Performance Measure 4, the adolescent homicide rate per 100,000 among youth aged 15 through 19, was 13.7 in 2000, representing the first year of no improvement during the period from 1996-2000. The annual objective was not achieved.

California law restricts the types of weapons that individuals can purchase, requires background checks of gun purchasers (including waiting periods), and requires citizens wishing to carry concealed weapons to obtain permits to do so. California school districts have also begun to implement programs to enhance school safety through a variety of strategies ranging from conflict resolution training to increased collaboration with local police departments.

MCH works with EPIC, the Office of Criminal Justice, the Attorney General, community-based organizations and others to explore youth homicide prevention efforts. EPIC is participating in an effort called "Shifting the Focus" that is designed to better coordinate youth violence prevention efforts among the participating partners and to create a unified vision and strategy to address youth violence in California.

b. Current Activities

/2004/ State Performance Measure 4, the adolescent homicide rate per 100,000 youth aged 15 through 19, was 13.4 in 2001, a decrease from the rate of 13.7 for 2000. The annual objective of 13.8 was met. //2004//

/2004/ In 2001, the California Attorney General's Office initiated the "Safe from the Start" strategy. The project targets children age 18 and younger, with an emphasis on children age 5 and younger, who have been exposed to family, school and/or community violence. The impact on youth age 15 through 19 will not show an effect until years to come. Other actions may have more immediate effects. The "School Violence Reduction Program" provides grants to schools, districts, and county offices of education for reducing violence on campus, teaching non-violent conflict resolution strategies to students and staff, and providing safe passage to and from school. The "School Law Enforcement Partnership" through CDE and the Attorney General's Crime and Violence Prevention Center, encourages schools and law enforcement agencies to develop interagency partnerships and activities

that improve school attendance, encourage good citizenship, and promote safe schools. Under this partnership, the "Gang Risk Intervention Program (GRIP)" establishes ties between youth, law-enforcement, businesses and community organizations to provide youth with counseling, job training, sports, and cultural activities. Another action taken to reduce adolescent (and adult) homicide rates is a California program that aims to reduce the use of "Saturday Night Special" handguns in urban areas. //2004//

c. Plan for the Coming Year

/2004/ The MCH Branch is working with NAHIC and the AHC to develop the capacity for increased coordination between primary care, mental health, and schools. DHS is conducting ongoing injury surveillance to look at broad statewide patterns and gathering data to better understand the risk factors and circumstances that can lead to specific types of injury. DHS also has an online injury prevention database that generates individualized county level tables (by age, race, location, etc.). Local MCAH jurisdictions have utilized this resource to assist with program planning for adolescent homicide prevention. Two surveillance projects of special interest include a statewide child abuse and neglect fatality monitoring system and the Firearm Injury Surveillance Program. These projects provide data on incidence for program planning purposes and to inform policy makers of possible changes in regulations or direction of injury control programs. //2004//

State Performance Measure 5: *The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.*

a. Last Year's Accomplishments

The rate of motor vehicle deaths among 15 through 19 year olds, State Performance Measure 5, showed a significant downward trend from 1990-98, falling from 27.3 to 17.2 per 100,000 15 through 19 year olds. From 1997-98, the rate continued to decline from 18.0 to 17.2 deaths per 100,000. The objective of 17.5 deaths per 100,000 was reached. Despite this progress, motor vehicle accidents remain the leading cause of death among teenagers and young adults, aged 15 through 19 years. Continued declines are expected in the rates of motor vehicle deaths for both age groups. Among adolescents, the introduction of a graduated driving license is expected to further reduce motor vehicle-related deaths.
/2002/ SPM 5, was 13.9 in 1999. The annual objective of 15.2 was achieved and surpassed in 1999. Caution should be applied in comparing 1999 mortality-related measures to rates prior to that year because of the uncertainty regarding the comparability of data resulting from the shift from the ICD9 codes used through 1998 to the ICD10 codes used in 1999.
/2003/ State Performance Measure 5, fell from 13.9 deaths per 100,000 in 1999 to 13.3 in 2000, maintaining the improvement that has been observed in recent years. Despite this improvement, the annual objective of 13.2 was not achieved. State policies of graduated driving license, emphasis on road safety and enforcement of traffic laws, as well as avoidance of alcohol when driving, continue to aim at reducing the adolescent motor vehicle mortality rate.

/2002/ The California Childhood Injury Prevention Center continues to provide technical assistance on injury prevention activities to the Title V agency at the State and local levels. This assistance includes support in data analysis and program development. CCIPP presented information to the California County MCH Directors on the availability and use of California-specific data sources for injury prevention. The information was posted on the CIPPP website with links to the actual data sources. CCIPP has been a valuable resource in the development of the injury-related sections of the adolescent health plan and in providing input and guidance on injury prevention in early childhood to the Prop10 commissions. /2003/ CIPPP is currently working with five local MCAH programs to organize injury prevention activities and integrate such activities into existing programs. In addition, CIPPP works with the MCH Branch to organize the annual childhood injury prevention conference, which brings together a wide array of organizations, agencies, and individuals working in or concerned with injury prevention.

b. Current Activities

/2004/ State Performance Measure 5 is the rate of deaths caused by motor vehicle injuries to adolescents aged 15 through 19 years. Although this rate continually dropped from 1997 to 2000, in 2001 it rose 35 percent, from 13.3 deaths per 100,000 in 2000 to 18.0 deaths per 100,000 in 2001. The 2001 rate did not achieve the 2001 objective of 12.2. While the reasons for the increase have not been identifieda 30 percent increase was also seen in Colorado and in 2002, a rise was seen nationally./2004//

/2004/The California Safe Communities Program, the CIPP at San Diego State University, and Kid's (license) Plates work towards reducing childhood injury. Many motor vehicle deaths are associated with being drunk or drugged while driving. In 1998, 24 percent of teen drivers ages 15 to 20 involved in fatal motor vehicle crashes had been drinking alcohol. During recent years, the California Highway Patrol has been successful in reducing the number of deaths and injuries caused by the drinking driver through enforcement and extensive education and public awareness programs. These include: "Sober Graduation," recognized internationally as an effective anti-DUI program targeting high school seniors and raising their awareness of the dangers of drinking and driving; the "Designated Driver Program;" "Red Ribbon Week", an annual event to increase the public's awareness of the problems associated with using illicit drugs; and the "El Protector" program which was established in response to the disproportionate amount of fatal accidents and driving under the influence arrests involving Hispanic youth. //2004//

c. Plan for the Coming Year

/2004/The California Safe Communities Program will promote new partnerships between traffic safety and health experts. The CIPP will continue to provide data and technical assistance in the development, implementation and evaluation of injury prevention programs and create linkages between agencies, researchers, and advocates. Money from the sale of Kid's Plates will continue to support child injury and abuse prevention programs. The MCH Branch continues to fund selected counties for local injury control programs. Many counties are also participating in the Safe Kids Coalitions, child passenger safety checks, and bicycle helmet education. State law now requires that persons under 18 years of age wear a helmet while operating a nonmotorized scooter or skateboard, in-line or roller skates or riding as a passenger on a nonmotorized scooter or skateboard as a

passenger. Counties are also using the Child Death Review data and Fetal Infant Mortality Review team data to identify trends and associated factors to raise awareness for systems changes. //2004//

State Performance Measure 6: *The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System.*

a. Last Year's Accomplishments

The incidence of neural tube defects among fetal deaths and live births, State Performance Measure 6, is determined from the CBDMP. The rate of neural tube defects (NTDs) fell from 6.9 to 5.3 per 10,000 fetal deaths and live births from 1996 to1997, after rising in the previous year. The 1997 annual objective of 4.2 NTDs per 10,000 live births and fetal deaths was not met. Nevertheless, the rate of NTDneural tube defects has shown a statistically significant downward trend from 1990 to 1997., with a decline from 8.0 to 5.3 per 10,000 live births and fetal deaths.

The prenatal and preconceptional use of folic acid and multivitamin supplements is being monitored in the Maternal and Infant Health Assessment (MIHA) survey. MIHA data will help identify populations with lower intake of folic acid. Based on these activities and other relevant State programs, the rate of neural tubes defects is expected to decline in the next five years.

/2002/ SPM 6 has continued to rise; 6.0 in 1998 and 9.1 in 1999. The annual objectives for both years were not met. The sample included in the California Birth Defects Monitoring Program system was reduced in 1998 to include eight counties in the Central Valley. The eight counties were deemed sufficient by the CBDMP for surveillance purposes in this state. The MCH Branch is working with the California Birth Defects Monitoring Program to assess possible reasons for the increased reported in 1999. In addition, the MCH Branch is working with the California Folic Acid Committee to increase public awareness of the role of folic acid in the prevention of NTDs.

/2003/ In 2000, there were 7.3 neural tube defects per 10,000 live births plus fetal deaths, State Performance Measure 6. The data, which is provided by the CBDMP, is based on a sample from eight counties in the Central Valley. The incidence declined from 9.1 per 10,000 in 1999 but the 2000 objective of 4.6 was not achieved.

/2003/ In February 2002, the MCH Branch produced and distributed a new Spanish and English folic acid pamphlet and poster entitled Folic Acid: Every Woman, Every Day. The material was sent to all MCH Branch contractors, distributed through the WIC Branch and the GDB, and posted on the MCH website. In summer 2001, the revised Steps To Take: Guidelines for Comprehensive Perinatal Services Program included a new prenatal handout entitled "Get the Folic Acid You Need." In the 2002 Guidelines for Care, the CDAPP updated its folic acid recommendation to 600 micrograms of folic acid during pregnancy. The MCH Branch and the California March of Dimes have collaborated on drafting a grant proposal to develop a folic acid media campaign and provider training.

b. Current Activities

/2004/ In 2001, State Performance Measure 6, the incidence of NTDs, declined to 5.4 per 10,000 live births and fetal deaths from 7.3 in 2000. The performance objective of 6.7 is met. However, the change is not statistically significant. //2004//

/2004/ During 2001 the MCH Branch added a new prenatal handout about folic acid to the Guidelines for Comprehensive Perinatal Services. The MCH Branch has continued to develop educational materials including folic acid guidelines in both the Nutrition and Physical Activity Guidelines for Adolescents and the revised Guidelines for Care for the CDAPP. DHS has also promoted folic use by: 1) performing phenylalanine monitoring to all individuals with PKU seen at approved metabolic centers throughout California at no cost to patient, 2) Maternal PKU Project addresses PKU issues among women of childbearing age, 3) Newborn Screening Sickle Cell Counseling Centers provide follow-up services, 4) GeneHELP Resource Center assists health care providers, other professionals and the public with selection, utilization and development of accurate and appropriate educational materials on genetic screening, genetic disorders and services. //2004//

/2004/ The MCH Branch authored, "Women's Use of Folic Acid Supplements and Knowledge of Its Importance for Prevention of Birth Defects in California". This was a Data Point for the Women's Health Survey and can be found on the Office of Women's Health web page. //2004//

c. Plan for the Coming Year

/2004/ The reduction of the rate of neural tube defects through improved folate consumption is an important element of the Title V programs to improve infant health status and reduce disparities across racial and ethnic groups.The MCH Branch will continue to collaborate with and provide technical assistance to local MCH programs, such as BIH, AFLP, and CPSP; the March of Dimes; other programs in DHS, such as WIC, GDB, and the Nutrition Network; and other local agencies, to promote the consumption of folic acid among women of reproductive age. //2004//

State Performance Measure 7: *The percent of California Children's Services (CCS) enrolled children registered in CMS Net, the statewide automated case management and data collection system for CCS.*

a. Last Year's Accomplishments

The percent of CCS enrolled children registered in CMS Net, SPM #7, was developed in response to the identified need to facilitate case management and coordination of care.
/2002/ Though the percent of CCS children entered into CMS Net, SPM 7, increased to 23.3 percent in FY 1999-2000, this did not meet the targeted goal for the year. Linking CMS Net with the Medi-Cal system and development of electronic verification of both client eligibility and medical providers has required considerable technical activity. CMS Net data entry objectives for 2001 to 2006 have been modified, to include additional, anticipated system adjustments. There are currently 46 counties using CMS Net and, as of May 2001, 42,383, or 29 percent of CCS

active cases were entered in the system(40).
/2003/ The percent of CCS children entered in CMS Net, State Performance Measure 7, increased to 36.3 percent for FY 2000-2001. This number has surpassed the objective of 29 percent. There are 49 counties currently using CMS Net. Though there are only nine counties not on the system, these nine include Los Angeles (55,452 cases) and Orange (15,828) counties, which together make up 45 percent of CCS children.

b. Current Activities

/2004/ The percent of CCS children entered in CMS Net increased to 41.6 percent for FFY 2001-2002, with the addition of several more counties. This number again passed the objective of 34 percent. There were 52 counties using CMS Net in 2002. Three very large counties, not yet on CMS Net, are San Diego, Los Angeles, and Orange and these represent 51 percent of the active CCS caseload. Alameda County is on CMS Net as of 2003, and it is anticipated that the remaining five counties, which also include San Mateo and Sacramento, will be on CMS Net by August 2004. //2004//

 View Attachment

c. Plan for the Coming Year

/2004/ 1) Continuing progress to convert all 58 counties to the CMS Net system. Currently 53 counties responsible for approximately 80,000 of the 180,000 children in the CCS program are part of the CMS Net system. In the next 12 months two additional counties, San Diego (November 2003)and San Mateo (February 2004) will be added to the system, and work will begin on conversion activities for Orange and Los Angeles Counties. 2) Implementation of the three remaining phases of the Enhancement 47 project that significantly modify the existing CMS Net system will conclude in 2004. Deloitte Consulting was hired to perform the enhancement work as well as maintain the existing CMS Net system. 3) Accomplishing training/implementation, post implementation, and scheduling and implementing site visits. 4) Providing ongoing help desk support to resolve issues, problems and data correction for all counties on CMS Net as well as those joining the system. //2004//

State Performance Measure 8: *The percent of women 18 years or older reporting intimate partner physical abuse in the past 12 months.*

a. Last Year's Accomplishments

State Performance Measure 9 (now SPM #8), examines the prevalence of self-reported intimate partner physical abuse among women eighteen years of age and older. Since this measure was not included in prior applications, progress is not assessed. Nonetheless, services are provided for these groups under programs such as the Black Infant Health Program, the Adolescent Family Life Program, and the CHDP program.

/2002/ This measure has been changed to State Performance Measure 8. In 1999, 6.4 percent of women 18 years or older reported experiencing intimate partner physical abuse in the past twelve months. The annual objective of 6.0 percent was

not achieved. Changes in the reported prevalence of intimate partner abuse are likely to reflect actual changes in the prevalence of the problem as well as changes in women's willingness to make such reports. This willingness may be increasing because of the heightened visibility of intimate partner abuse and its perception as a public health problem.

/2003/ In 2000, 5.7 percent of women 18 years or older reported experiencing intimate partner physical domestic violence (IPP-DV) in the past twelve months, State Performance Measure 8. The annual objective of 5.9 percent was achieved. Changes in the reported prevalence of IPP-DV are likely to reflect actual changes in the prevalence as well as changes in women's willingness to make such reports. Additionally, due to space limitations, IPP-DV questions were condensed slightly in the 2000 California Women's Health Survey (CWHS). These revisions could have had an effect on the measurement of IPP-DV.

To combat the serious health threat of domestic violence, the Battered Women's Shelter Program was established in 1994 as a result of legislative action. The program funds direct shelter services for abused women and their children and community prevention activities. The Domestic Violence Section of the MCH Branch provides a spectrum of enabling services to women threatened by domestic violence. Domestic violence agencies provide shelter-based services, domestic violence community prevention programs, evaluation, technical assistance and training projects designed to build capacity within organizations and communities to eliminate domestic violence issues. Program goals and objectives are based on "Preventing Domestic Violence: A Blueprint for the 21st Century", a strategic plan developed by the statewide Domestic Violence Advisory Council, which is convened and facilitated by MCH.
/2003/ Since 1998, the DV Section has been developing questions for and analyzing data from the annual statewide CWHS to better understand the characteristics of and risk factors associated with partner abuse among California women in addition to monitoring the prevalence of the problem. These data are used in intervention design and evaluation activities.

b. Current Activities

/2004/ In 2001, State Performance Measure 8, the percent of women 18 years or older reporting intimate partner physical abuse in the past 12 months, declined from 5.7 percent in 2000 to 5.2 percent in 2001. The annual objective of 5.6 percent was met. Women's willingness to report incidents may influenece these changes in rates. The DV Program continues to address issues of partner abuse through direct services to women in or at risk for an abusive relationship. These services include outreach and education to teens and culturally appropriate services for unserved/underserved populations, oversight of, and information dissemination and interchange for provider agencies, counseling for both women and children, and community awareness and prevention education programs. //2004//

/2004/ The Sonoma County MCH program has completed trainings to promote strategies for the early prevention of child maltreatment. In addition, home visits, referrals, and parenting education were provided to families with first time births. DV shelters funded by the MCH Branch have also targeted youth DV with programs that have connected teens to community resources and DV services in their area, and have provided training in relationship and conflict resolution skills to young people. To raise awareness and knowledge of DV issues specific to

immigrant and refugee families, professional staff were trained. This training allows them to gain a better understanding of cultural considerations when working in multi-ethnic communities, finding the appropriate resources, and learning how to intervene with families who have experienced DV. //2004//

c. Plan for the Coming Year

/2004/ The State budget constraints has reduced the DV technical assistance and training contracts that assist local shelters from ten to one for FY 2003-04. The remainder of the funding used to support these activities will be re-directed to direct services as many shelters are facing 25-50 percent reductions in donations and grant funding. //2004//

State Performance Measure 9: *The percent of youth aged 12-17 years who report smoking cigarettes in the past 30 days.*

a. Last Year's Accomplishments

/2002/ State Performance Measure 9 has been changed to State Performance Measure 8. The new State Performance Measure 9 is the percent of 12 to -17-year-olds who report smoking cigarettes in the past thirty days.

California has witnessed marked declines in the rate of smoking among the adult population., however similar gains have not been observed among youth. In 1998, 10.7 percent of youth 12-17 years old reported smoking cigarettes in the past thirty days. Based on data from the California Tobacco Control Section, this percent has shown no significant change over the past five years. Tobacco is the number one preventable cause of death. More than 80 percent of adult smokers had tried smoking by their 18th birthday and more than half had become regular smokers by that time. One of every three of the young people who become regular smokers each day nationally will have their lives shortened from tobacco-related diseases.

A portion of the funds becoming available to the State and counties from the cigarette surtax imposed following the passage of Proposition 10 will be allocated to youth smoking prevention. This State Performance Measure reflects California's commitment to the reduction of youth smoking. It relates directly to the priority need of improving the lifestyles of the state's children and adolescents. Services are population-based and designed to address specific risk factors. Federal Outcome Measures do not relate directly to the problem of youth tobacco.

b. Current Activities

/2004/ California has continued to see significant declines in the percentage of youth aged 12-17 who report smoking cigarettes in the past 30 days, as measured in random-digit-dial telephone surveys (State Performance Measure 9). Although consistent from 1994 through 1998 at approximately 11 percent, the prevalence in reported smoking declined to 7.0 percent in 2000, 5.9 percent in 2001, and 4.6 percent in 2002. Thus, from 1998 to 2002, youth smoking declined by about 58 percent. These declines are largely attributable to the 50-cent per pack tax increase on cigarettes that took effect in 1999 and the long-term, combined effect

on community norms around tobacco that resulted from the State's policy-focused comprehensive tobacco control program. The program's statewide media campaign, cessation help line (with tailored counseling for teens and pregnant women), some 100 local programs across the State based in local health departments and community based organizations, and the energetic efforts of four ethnic networks have succeeded since 1988 in reducing California's overall cigarette consumption at twice the rate of the rest of the nation; played an instrumental part in making virtually all indoor workplaces, including restaurants and bars, smoke free; and made tobacco in general less accessible, less acceptable, and less desirable among both adults and youth. //2004//

c. Plan for the Coming Year

/2004/ Future plans include increased focus of tobacco control efforts on countering tobacco industry marketing efforts, especially on tobacco advertising and promotions at the point of sale, where tobacco industry efforts have greatly intensified in recent years. DHS also plans to maintain smoke-free indoor air policies and their enforcement, and to continue the enforcement of laws against sales to minors, support the prohibition of smoking in busy outdoor public gathering places, and encourage voluntary smoke-free home policies.//2004//

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of children whose family income is less than 200 percent of the Federal Poverty Level who received at least one preventive medical exam during the fiscal year.				
1. Outreach efforts for children & families to access preventive health exams.	☐	☑	☐	☐
2. Participation on Head Start Advisory Board.	☐	☑	☐	☐
3. Working with school districts on CHDP Annual School Report.	☐	☐	☑	☐
4. Outreach to and recruitment of providers.	☐	☑	☐	☐
5. Work on MOUs between MCMC providers and CHDP programs.	☐	☐	☐	☑
6. Implement CHDP gateway.	☐	☐	☐	☑
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

	Pyramid Level

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of low-income children who are above the 95th percentile of weight-for-length (less than 2 years) or BMI-for-age (2-12 years), or overweight.				
1. Complete Healthy Eating and Childhood Overweight Prevention grants.	☐	☐	☐	☑
2. Continue Pilot Nutrition Network Project funded nutritionists (increase to 10).	☐	☐	☑	☐
3. Distribution of books and brochures about obesity/activity/health to CHDP providers.	☐	☑	☐	☐
4. Participation in coalitions on nutrition and physical activity.	☐	☑	☐	☐
5. Data collection from CHDP nutrition assessments for PEDNSS.	☑	☐	☐	☐
6. Develop and implement nutrition education, consultation, & training for CHDP providers.	☐	☑	☐	☐
7. Plan biannual CA Childhood Obesity Conference.	☐	☑	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The rate of deaths per 100,000 children aged 1 through 4 years caused by drowning in swimming pools.				
1. CCIP provides data & tech assistance in development, implementation & evaluation.	☐	☐	☐	☑
2. CCIP evaluates injury prevention programs & creates linkages between agencies.	☐	☐	☐	☑
3. CCIP evaluates injury prevention programs & creates linkage between researchers & advocates.	☐	☐	☐	☑
4. Money from sale of “Kid's Plates,” used to support child injury and abuse prevention programs.	☐	☐	☑	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

4) The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by homicide.				
1. Work with NAHIC and AHC to increase coordination with primary care, mental health and schools.	☐	☐	☐	☑
2. CCCIP/SDSU serves as resource center on child & adolescent injury prevention.	☐	☐	☐	☑
3. CCCIP/SDSU provides data & technical assistance in development/evaluation injury prevention programs	☐	☐	☐	☑
4. CCCIP/SDSU creates linkages between agencies, researchers & advocates.	☐	☐	☐	☑
5. Money from the sale of Kid's Plates is used to support child injury & abuse prevention programs.	☐	☐	☑	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
5) The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.				
1. CSCP intends to promoting new partnerships between traffic safety & health experts.	☐	☐	☑	☐
2. CCCIP/SDSU provides data & technical assistance in development/evaluation injury prevention programs	☐	☐	☐	☑
3. CCCIP/SDSU provides data & technical assistance in implementation of injury prevention programs.	☐	☐	☐	☑
4. CCCIP/SDSU creates linkages between agencies, researchers and advocates.	☐	☐	☐	☑
5. Money from the sale of Kid's Plates is used to support child injury & abuse prevention programs.	☐	☐	☑	☐
6. Participation in Safe Kids Coalition, helmet education, child passenger safety checks.	☐	☐	☐	☑
7. Identifying trends and factors to raise awareness for systems changes.	☐	☐	☐	☑
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

6) The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System.				
1. Perform phenylalanine monitoring to individuals with PKU at approved metabolic SCCs	☑	☐	☐	☐
2. Maternal PKU Project addresses PKU issues among women of childbearing age.	☐	☐	☑	☐
3. Newborn Screenng Sickle Cell Counseling Centers provide follow-up services.	☐	☐	☑	☐
4. GeneHELP Resource Center assists health providers and the public with educational materials.	☐	☑	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
7) The percent of California Children's Services (CCS) enrolled children registered in CMS Net, the statewide automated case management and data collection system for CCS.				
1. Continuing progress to convert all 58 counties to the CMS Net system.	☐	☐	☐	☑
2. Implementation of the three remaining phases of the enhancement 47 project.	☐	☐	☐	☑
3. Training/implementation, post implementation, scheduling/ implementing site visits.	☐	☑	☐	☐
4. Ongoing help desk support for all counties on CMS Net.	☐	☑	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
8) The percent of women 18 years or older reporting intimate partner physical abuse in the past 12 months.				

1. Contract providing funding for direct services including DV shelter.	☑	☐	☐	☐
2. Education and services to teens and other unserved/ underserved populations.	☐	☐	☑	☐
3. Oversight of, and information dissemination and interchange for provider agencies.	☐	☐	☑	☐
4. Counseling for women and children.	☐	☐	☑	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) The percent of youth aged 12-17 years who report smoking cigarettes in the past 30 days.				
1. Continue countering tobacco industry marketing efforts.	☐	☐	☐	☑
2. Tobacco Control Program funding a statewide toll-free smoking cessation Helpline.	☐	☐	☑	☐
3. Youth Tobacco Survey & CA Tobacco Survey supporting surveillance efforts.	☐	☐	☐	☑
4. Maintain and enforce smoke-free indoor air policies.	☐	☑	☐	☐
5. Encourage voluntary smoke-free home policies.	☐	☑	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

E. Other Program Activities

Each county has its own phone number/hotline that citizens can call to obtain information regarding prenatal care services and programs. There also is a Statewide Toll free telephone hotline run by the AIM Program.
/2004/ In FFY 2002, approximately 35,068 calls were received for the MCH toll-free information hotline. The number of calls decreased from previous years; in FFY 2001 approximately 45,323 calls were received and in FFY 2000 44,428 calls were received. The reasons for this decrease are not known. //2004//
/2004/ DHS has established a Bioterrorism (BT) team that is part of a multidisciplinary DHS initiative to strengthen public health infrastructure to detect, identify, investigate, and control illnesses due to biological or chemical terrorist attacks. The team will focus on enhancing state and local health surveillance and epidemiologic response capacity

for diseases due to biological or chemical agents. If a suspected bioterrorism event occurs, the BT team will also provide epidemiologic assistance and coordination to local health departments. DHS has prepared and distributed a guide for hospitals called "California Hospital Bioterrorism Response Planning Guide." This Guide includes treatment recommendations for pregnant women (for example, the smallpox vaccine is contraindicated for pregnant women), infants, and children as well as for non-pregnant adults, in case of exposure to the agents most likely to be used in a terrorist event. //2004//
/2004/ The MCH and CMS Branches collaborate with the March of Dimes on perinatal health issues. March of Dimes works to improve the health of infants by promoting the prevention of birth defects and infant mortality. One of the methods for accomplishing this mission is to provide community awareness and education in order to decrease the disparities in infant mortality among ethnic groups. //2004//
/2004/ The March of Dimes launched a 5-year Prematurity Campaign in January 2003. The goal of this $75 million campaign is to invest in research, education and community programs in order to identify the causes of prematurity and develop strategies to improve birth outcomes. The five aims of the Prematurity Campaign are to: 1) raise public awareness of the problems of prematurity; 2) educate pregnant women about the signs of preterm labor; 3) assist practitioners with tools to identify women at risk of preterm birth and for risk reduction; 4) invest in research into the causes of preterm birth; and 5) increase women's and children's access to health insurance.//2004//

/2004/ Another major March of Dimes campaign currently underway is the Alcohol and Pregnancy Campaign, which aims to increase knowledge and awareness about the consequences of substance use during pregnancy. Alcohol and drug use during pregnancy continue to be a major cause of negative birth outcomes. In San Bernardino County, nearly 15 percent of women have used alcohol and/or drugs during their pregnancy. Nationally 70-80 percent of children in the foster care system have been directly and significantly impacted by substance and/or alcohol use by parents and guardians. The March of Dimes poster campaign was developed to address the high rate of alcohol and drug use during pregnancy. Posters were developed in collaboration with community members via 12 focus group sessions. Distribution of the posters targeted zip code areas within San Bernardino County that have the poorest birth outcomes. Pre-intervention survey results revealed that community education is needed to increase awareness regarding the repercussions of perinatal drug use.//2004//

F. Technical Assistance

/2002/ CMS is requesting $25,000 to develop indicators for measuring quality of services given to California CSHCN. We would like to request funding for a leader in this field, such as Henry Ireys, PhD. of the University of Illinois, to provide technical consultation.

/2003/ No funding was received.

/2004/The MCH Branch requests assistance from a statistician to help in the design, sampling, weighting, and analysis of a needs assessment and other oral health and dental research projects. National Performance Measure 9 is "Percent of third grade children who have one or more sealed permanent molar teeth" is the only performance measure related to oral health, but this indicator does not give an adequate overall picture of oral health in the MCH population including pregnant women. In California, the only comprehensive assessment of children's oral health needs was completed in 1993-94. That survey showed that 11.5 percent of third graders had protective sealants, far below the Healthy People 2000 and 2010 goal of 50 percent. For this and other projects such as developing standards for trend analyses, California MCH requests an appropriate statistician. //2004//

/2004/ The California FIMR program operates in 19 counties. The MCH Branch requests a staff person to conduct a three-year retrospective review of FIMR case summaries reported to the State and prepare and publish a report on risks and proposed interventions. The proposed project would abstract case data from the FIMR files and compile the information into a database. A statewide report would be produced on the findings from the case reports submitted to the State, a discussion of how the FIMR program has impacted MCH programs, limitations in the content and methodology of data reporting, and the recommendations for improving the program. Current data collection forms and those of the National FIMR abstract forms would be compared and the implementation of the results would be considered. These results would be disseminated throughout MCH programs In addition, a one-day meeting would be convened among interested and participating FIMR counties to review the report findings, identify best practices in FIMR implementation, and establish new directions for the FIMR program including the implementation of the Perinatal Periods of Risk approach.//2004//

/2004/The CMS Branch has five Federal Performance Measures this year that are from the National Survey of CSHCN. The CMS Branch has only a crude understanding of these measures and requests an expert from the CDC to provide training on the National Survey and any related surveys.//2004//

V. Budget Narrative

A. Expenditures

/2002/ The budgeted and expended funds for FFY 2002 are presented on Forms 2, 3, 4, and 5. Funds are listed by source (Forms 2 and 3), by population group served (Form 4), and by type of services (Form 5). Funds reported for FFY 2002 are presented using the methodology from the Federal MCH Bureau's most recent guidance.

Significant year-to-year budget variations that appear on Forms 3,4, and 5 are attributable to the new process of including and displaying all funding sources for services for the MCH population. The total budgeted amount in FFY 1997 did not reflect all the budgeted Title XIX funds available, while the FFY1999, 2000, and 2001 budgets reflect the total Title XIX and Title XXI funds budgeted for Title V related services. These changes are reflected on all applicable forms (Forms 2, 3, 4, and 5).

/2004/ The budget and expenditures for FFY 2004 are presented in Forms 2, 3, 4, and 5. //2004//

B. Budget

Since the enactment of OBRA 89, California has maintained the availability of Title V funds under both the maintenance of effort and the match requirements. The California Title V agency will continue to do so in the coming year.

The proposed allocation of Title V funds for California for FFY2001 is $43,010,496. The proposed activities are based on this figure. Preventive and primary services for pregnant women, mothers, and infants are designated to receive $13,619,786 (31.67 percent of the total), preventive and primary services for children to receive $14,122,761 (32.83 percent), and CSHCN to receive $13,054,925 (30.35 percent). Administrative costs are proposed at $2,213,024 (5.15 percent).
/2002/ The proposed allocation of Title V funds for California for FY2002 is $42,994,205. Preventive and primary services for pregnant women, mothers, and infants are designated to receive $13,279,689 (30.89 percent of the total), preventive and primary

services for children to receive $14,284,664 (33.22 percent), and CSHCN to receive $13,216,828 (30.74 percent).
/2003/ The proposed allocation of Title V funds for California for FY2003 is $44,289,287. Preventive and primary services for pregnant women, mothers, and infants are designated to receive $13,920,846 (31.43 percent of the total), preventive and primary services for children to receive $14,525,388(32.80 percent), and CSHCN to receive $13,420,028 (30.30 percent).
/2004/ The proposed allocation of Title V funds for California for FY2004 is $44,341,423. Preventive and primary services for pregnant women, mothers, and infants are designated to receive $13,192,755 (29.75 percent of the total), preventive and primary services for children to receive $14,897,624 (33.59 percent), and CSHCN to receive $13,820,050 (31.16 percent).//2004//

State Match/Overmatch:
California will receive $43,010,496 in Federal Title V Block Grant funds for FFY 2001. The required match is $32,257,872. California's FFY 2001 expenditure plan for MCH programs includes $664,726,146 in State funds. Consequently, the state-funded expenditures for preventive and primary health care services for the Title V populations exceeds the required 4:3 matching ratio.
/2002/ California will receive $42,994,205 in Federal Title V Block Grant funds for FFY 2002. The required match is $32,245,654. California's FFY 2002 expenditure plan for MCH programs includes $772,185,068 in State funds. Consequently, the state-funded expenditures for preventive and primary health care services for the Title V populations exceeds the required 4:3 matching ratio.
/2003/ California will receive $44,289,287 in Federal Title V Block Grant funds for FFY 2003. The required match is $33,216,965. California's FFY 2003 expenditure plan for MCH programs includes $777,395,553 in State funds. Consequently, the state-funded expenditures for preventive and primary health care services for the Title V populations exceed the required 4:3 matching ratio.
/2004/ California will receive $44,341,423 in Federal Title V Block Grant funds for FFY 2004. The required match is $33,256,067. California's FFY 2004 expenditure plan for MCH programs includes $849,821,442 in State funds. Consequently, the state-funded expenditures for preventive and primary health care services for the Title V populations exceed the required 4:3 matching ratio.//2004//

Administrative Costs Limits:
In FFY 2001, no more than 10 percent of the Federal Title V MCH Block Grant funds will be used for administrative costs related to each program component. During FFY 2001, California will expend only 5.15 percent of Title V funds on administrative costs.
/2002/ In FFY 2002, no more than 10 percent of the Federal Title V MCH Block Grant funds will be used for administrative costs related to each program component. During FFY 2002, California will expend only 5.15 percent of Title V funds on administrative costs.
/2003/ In FFY 2003, no more than 10 percent of the Federal Title V MCH Block Grant funds will be used for administrative costs related to each program component. During FFY 2003, California will expend only 5.47 percent of Title V funds on administrative costs.
/2004/ In FFY 2004, no more than 10 percent of the Federal Title V MCH Block Grant funds will be used for administrative costs related to each program component. During FFY 2004, California will expend only 5.48 percent of Title V funds on administrative costs.//2004//

Definition of Administrative Costs:
In this Application, administrative costs are defined as the portion of the Title V dollars used to support staff in the MCH and CMS Branch Operations Sections. Funds

supporting State program and data staff (but not administrative staff) in the MCH and CMS Branches are considered to be program rather than administrative costs.

Administrative costs include staff and operating costs associated with the administrative support of specific MCH Branch and CMS Branch programs. These support functions include, but are not limited to, contract management, accounting, budgeting, personnel, audits and appeals, maintenance of central contract files, and clerical support for these functions.

"30-30" Minimum Funding Requirement:
At least 30 percent of the MCH Title V Block Grant funds will be used for children's preventive and primary care services delivered within a system which promotes family-centered, community-based, coordinated care. At least 30 percent of the Title V Block Grant funds will be used to provide services to CSHCN delivered in a manner which promotes family-centered, community-based, coordinated care.

/2003/ In some cases, the DHS uses estimates to assess expenditures for both individuals served and the types of services provided. These estimates are based on the target population and program activities authorized in statute, excluding the State budget, and specified in the scope of work for each contractor. Requiring contractors to bill according to actual amounts spent on each type of individual served and by service provided is not possible within current administrative and fiscal policies. Changing State contractual policies would result in undue financial and administrative hardship to local governments and non-profit community-based organizations. This added burden without increased funding would result in many of them not being able to continue to provide needed services to women and children in the state.

Maintenance of State Effort:
The State Department of Health Services has an ongoing commitment to provide maternal and child health services to women and children within the State of California. This commitment includes continued support to local health jurisdictions, local programs, clinics and Medi-Cal providers for maternal and child health services.

It is the State's intent to ensure that State General Fund contributions to these local programs, which are also funded in part by the Federal Title V Block Grant, be administered by the MCH and CMS Branches. The State's General Fund contribution for FFY 2001 is $664,726,146, which is $557,567,396 greater than the State's General Fund contribution of $87,158,750 in base year FFY 1989.
/2002/ The State's General Fund contribution for FFY 2002 is $772,185,068, which is $685,026,318 greater than the State's General Fund contribution of $87,158,750 in base year FFY 1989.
/2003/ The State's General Fund contribution for FFY 2003 is $777,395,553 which is $690,236,803 greater than the State's General Fund contribution of $87,158,750 in base year FFY 1989.
/2004/ The State's General Fund contribution for FFY 2004 is $849,821,442 which is $762,662,692 greater than the State's General Fund contribution of $87,158,750 in base year FFY 1989.//2004//

Additional Program Budget Information:
The State Children's Health Insurance Program (Title XXI of the Social Security Act) makes available Federal funds for states to expand health insurance to uninsured children. California's response to this legislation is the Healthy Families Program. With this program, California has expanded access to health coverage for uninsured children through: 1) A health insurance program for infants and children whose family incomes are above those which provide eligibility for no-cost Medi-Cal but are at or below 250

percent of the FPL (this was increased from 200 percent of the FPL in November 1999). 2) Changes to the Medi-Cal system, which simplifies eligibility to increase enrollment of the eligible population. 3) Coverage through the Access for Infants and Mothers (AIM) program of infants up to 12 months whose family income is between 200 and 250 percent of the FPL.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

 View Attachment

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.